| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-----------------------|--|-------------------------------|--------------------------|
| | | MHL032-412 | B. WING | | 09/2 | ≀ 0/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| BAART (| COMMUNITY HEALTH | CARE | TH MANGUN NC 27701 | I STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | | w up survey was completed 2024. Deficiencies were cited. | | | | |
| | categories: 10A NO Opioid Treatment, 2 Substance Abuse In (SAIOP) and 10A N | sed for the following service CAC 27G .3600 Outpatient IOA NCAC 27G .4400 Intensive Outpatient Program ICAC 27G .4500 Substance Sive Outpatient Treatment | | | | |
| | Outpatient Opioid T Substance Abuse Ir (SAIOP) has a curre Substance Abuse C Treatment Program census of 0. The s | urrent census of 318 for .3600 freatment. The .4400 intensive Outpatient Programment census of 0 and the .4500 comprehensive Outpatient (SACOT) has a current urvey sample consisted of a clients and 1 deceased client. | | | | |
| V 113 | 27G .0206 Client R | ecords | V 113 | | | |
| | (a) A client record sindividual admitted contain, but need no (1) an identification (A) name (last, first (B) client record nut (C) date of birth; (D) race, gender and (E) admission date; (F) discharge date; (2) documentation of developmental disardiagnosis coded act (3) documentation of assessment; | face sheet which includes: , middle, maiden); mber; ad marital status; of mental illness, bilities or substance abuse | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
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| | | | 7. BOILDING. | | | R | |
| | | MHL032-412 | B. WING | | | 0/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART (| COMMUNITY HEALTH | ICARE | TH MANGUM , NC 27701 | I STREET, SUITE 300 & 400 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| V 113 | (5) emergency inforshall include the nare number of the personal sudden illness or an and telephone numphysician; (6) a signed statem responsible personemergency care from (7) documentation (8) documentation (9) if applicable: (A) documentation diagnosis according of Diseases (ICD-9) (B) medication order (C) orders and copto (D) documentation administration error (b) Each facility sharelative to AIDS or only in accordance | rmation for each client which me, address and telephone on to be contacted in case of ecident and the name, address ber of the client's preferred ent from the client or legally granting permission to seek om a hospital or physician; of services provided; of progress toward outcomes; of physical disorders g to International Classification -CM); ers; ies of lab tests; and | V 113 | | | | |
| | facility failed to mai in the client records | et as evidenced by: views and interviews, the ntain required documentation s affecting 4 of 21 audited and #8). The findings are: | | | | | |
| | Review on 9/17/24 -Admission date of -Diagnosis of Opioi Dependence-Unco | d | | | | | |

Division of Health Service Regulation

STATE FORM 6899 ZPPL11 If continuation sheet 2 of 32

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | | | F | |
| | | MHL032-412 | B. WING | | 09/2 | 0/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE | H MANGUM NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 113 | / 113 Continued From page 2 V 113 | | | | | |
| | -There was no sign | ed statement from the client n to seek emergency care from | | | | |
| | -Admission date of -Diagnosis of Opioi -There was no sign | d Use Disorder- Severe. ed statement from the client n to seek emergency care from | | | | |
| | -Admission date of -Diagnosis of Opioi -There was no sign | d Use Disorder- Severe. ed statement from the client n to seek emergency care from | | | | |
| | -Admission date of -Diagnosis of Opioi -There was no sign | d Use Disorder- Severe. ed statement from the client n to seek emergency care from | | | | |
| | -She completed the with clients on her coshe was not aware consent form. | 4 with staff #2 revealed: admission documentation caseload. e of the emergency medical ne seeing this form." | | | | |
| | -All consents should admission processThe counselors we medical care consections admission package. | ere not aware the emergency ent existed. supposed to be a part of the | | | | |

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STATE FORM 5899 ZPPL11 If continuation sheet 3 of 32

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | 7. BOILDING. | | F | ₹ |
| | | MHL032-412 | B. WING | | | 0/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | II.ARF | TH MANGUN , NC 27701 | I STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETE DATE |
| V 113 | Continued From pa | ige 3 | V 113 | | | |
| | for clients #2, #3, # | 7 and #8. | | | | |
| V 233 | 27G .3601 Outpt. C | Opiod Tx Scope | V 233 | | | |
| | provides periodic s individual an oppor changes in his lifes other medications a treatment in conjunt rehabilitation and m (b) Methadone and for use in opioid tredetoxification and mopioid dependent in (c) For the purpose and other medication treatment shall be a doses for a period (d) For individuals physiologically addleast one year beformethadone and other use in opioid treatment and treatment and other methadone and ot | epioid treatment facility ervices designed to offer the tunity to effect constructive tyle by using methadone or approved for use in opioid action with the provision of medical services. d other medications approved eatment are also tools in the ehabilitation process of an | | | | |

6899

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ZPPL11 If continuation sheet 4 of 32

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/S IDENTIFICAT | UPPLIER/CLIA ION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COME | SURVEY PLETED |
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| | | | | | | | R |
| | | MHL032- | 412 | B. WING | | 09/2 | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE | | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | | ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN | ED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 233 | Continued From pa | age 4 | | V 233 | | | |
| | This Rule is not m Based on record re facility failed to pro affect constructive by using methadon provision of rehabil affecting 13 of 21 a #5, #7, #8, #9, #10 findings are: | eviews and intervide services de changes in the e in conjunction itation and mediudited clients (7, #12, #13, #14, #10A NCAC 27G | views, the esigned to client's lifestyle in with the lical services #1, #2, #3, #4, and #15). The | | | | |
| | (Tag 235) Based or the facility failed to certified drug abus substance abuse of | have a minimule counselor or o | m of one certified | | | | |
| | Cross Reference: OUTPATIENT OPICOPERATIONS (Tagreviews and intervifailed to assure concern Part 8 which reduring treatment for 21 audited client #12 and #13). | OID TREATME g 237). Based cews, the facility inpliance with recequire an annur Opioid Addicti | NT - on record management egulations in 42 al physical on affecting 9 | | | | |
| | Cross Reference: OUTPATIENT OPICOPERATIONS (Tagreviews and interviensure during the foreatment, clients accounseling session audited clients (#3) all subsequent year client attend at least month affecting 12 #4, #5, #7. #8. #9, and C) failed to ensure outpatient of the control of the contro | OID TREATME g 238). Based of ews, the facility irst year of cont attend a minimulus a month affect g; B) after the fir ars of continuous at one counselir of 21 audited c #10, #12, #13, 3 | NT - on record failed to A) inuous m of two cting 1 of 21 st year and in s treatment a ng session per lients (#1, #2, #14 and #15); | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | R |
| | | MHL032-412 | B. WING | | 09/ | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | CARE 800 NOF | RTH MANGUM | STREET, SUITE 300 & 400 | | |
| DAART | OOMINONITI TILALIT | DURHAI | W, NC 27701 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 233 | Continued From pa | ge 5 | V 233 | | | |
| | | ositive Urine Drug Screen f 21 audited clients (#2, #3, #12). | | | | |
| | 9/20/24 written by t (TCD) revealed: "What immediate a ensure the safety o V233 -BAART Durham (f address deficiencie | of the Plan of Protection dated he Treatment Center Director ction will the facility take to f the consumers in your care? acility) will do the following to s: hired within 45 days. There | | | | |
| | will be a training pla staff on documenta Operations (RDO) a assistant on 9/23 a physicals/annuals. with the Clinical Tea compliance. TCD w gather their though V235 | an created for all onboarding tion. Regional Director and TCD will train medical and will begin scheduling. There will be a weekly meeting am and Medical to ensure will be meeting with patients to a sand needs. | | | | |
| | following to address -Continue to acc -TCD will review Staffing Agency] da -TCD will sched applicants within 24 -Offers will be r market analysis pro Human Resources] -All qualified ap within 2 weeks of a V237 -Director will run se to identify patients of | vertise via all job boards. v [Licensee Parent Company' ily for qualified applicants. dule interviews for qualified hours. nade utilizing the current ovided by [Parent Company's (HR). plicants will be onboarded ccepting offer. rvices due report every month due for physicals. vill contact and schedule | | | | |
| | | D) and Physician Assistant | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | | SURVEY PLETED |
|--------------------------|--|---|--------------------------|--|--------------------------------|----------------------------|
| | | | A. BUILDING. | | | , |
| | | MHL032-412 | B. WING | | | २ 2 <mark>0/2024</mark> |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | ODRESS, CITY, S | STATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | II.ARF | TH MANGUN 1, NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| | completed and doc V238 -All vacant Counse within 45 daysCounseling Super provide supervision documentationAll Counselors will documentation and -BAART Durham (f Protocols- 2x/mont there after. Describe your plans happens: V233 -RDO and TCD will | sure that physicals are sumented in a timely manner. Iling positions will be filled visor has been hired and will a to counselors regarding receive training on proper I timelines for completion. Facility) will follow State the for 1st year and 1x/month as to make sure the above | | | | |
| | and provide training needed. V235 -RDO will meet with and processTCD will inform RD applicantsRDO will continue weekly regarding vav237 -Medical Assistant before to remind of -Lead nurse will foll to ensure that patie physicals complete -TCD will meet with scheduled appointr with patients compl V238 | address any deficient areas g and additional support as any additional support as any additional support as any according to meet with recruiting team accancies. Will call all patients the day appointment for physicals. Iow up with Medical Assistant ents have been scheduled and d. The Lead Nurse to review ments and ensure compliance leting annual physicals. | | | | |

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STATE FORM 5899 ZPPL11 If continuation sheet 7 of 32

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | | SURVEY PLETED |
|--------------------------|---|---|---------------------------|---|-------------|--------------------------|
| | | | A. BUILDING. | | | R |
| | | MHL032-412 | B. WING | | | 20/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | 1CARE | RTH MANGUN M, NC 27701 | I STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE |
| V 233 | Continued From pa | age 7 | V 233 | | | |
| | -Counselors will co-TCD will complete monthAll of this is to ens Documentation and The facility served outpatient methado disorder. The cens was 318 clients. Or Director were availa #1 and #2 had a cathe Director had a clients did not have the 16 clients audite counseling session clients audited did address their positifacility failed to con Treatment Authority Abuse and Mental (SAMHSA) or Drug (DEA) standards of were not completed audited. Being undunable to meet the assist in treatment use/misuse. This deficiency con which is detrimental | mplete peer audits monthly. 10 random chart audits per ure compliance with d Chart Audits." adult clients who received one treatment for opioid use sus at the time of the survey nly two Counselors and the able to counsel clients. Staff aseload of 51 clients each and caseload of 53 clients. 163 a a counselor assigned. 13 of ed did not receive monthly as as required and 7 of the 21 not receive counseling to ve Urine Drug Screens. The nply with the State Opioid y (SOTA), the Substance Health Services Administration f Enforcement Administration f annual physical exams that d for 9 of the 21 clients erstaffed rendered the clinic complex needs of clients to | n | | | |
| V 235 | 27G .3603 (A-C) O | utpt. Opiod Tx Staff | V 235 | | | |
| | counselor or certifie | 603 STAFF one certified drug abuse ed substance abuse counseld and increment thereof shall be | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
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| | | | A. BOILDING. | | | R |
| | | MHL032-412 | B. WING | | | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | II.ARE | H MANGUM , NC 27701 | I STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| V 235 | on the staff of the fithis prescribed ratio individual who is considered individual in the following: (a) the withdress on the fit in the following: (b) Each facility should be following: (c) Each direct carcontinuing education the following: (d) nature of (e) the withdress on the following: (f) nature of (g) the withdress on the following in the following: (g) group and | acility. If the facility falls below o, and is unable to employ an ertified because of the tified persons in the facility's may employ an uncertified part this employee meets the ements within a maximum of 26 ate of employment. The fained in the following areas: se withdrawal symptoms; and is of secondary complications and to include understanding of addiction; rawal syndrome; and the family therapy; and the fa | V 235 | | | |
| | Based on record re facility failed to hav drug abuse counse | et as evidenced by: eviews and interviews, the e a minimum of one certified elor or certified substance each 50 clients. The findings | | | | |
| | -The facility had a | of facility records revealed: census of 318 clients. o full time substance abuse Director. | | | | |

Division of Health Service Regulation

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| MHL032-412 MAME OF PROVIDER OR SUPPLIER BAART COMMUNITY HEALTHCARE BOUNDATH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701 (X4) ID PREPIX I (EACH DEPICIENCY MUST BE PRECEDED BY PULL) TAG CROSS-REFERENCE OF THE APPROPRIATE DEPICIENCY V 235 Continued From page 9 V 235 Continued From page 9 V 235 Continued From page 9 Interview on 9/19/24 with Client #17 revealed: -She had a new counselorThis was the second counselor she had this yearShe met 1 hour monthly with her counselor, but she tried to see her every 2 weeks -"I try to squeeze my head in every two weeks." -She had one to the point that she did not want to get very close to the counselors as they may leave soon afterShe had one other issues with the facility"I feel well cared for by staff." Interview on 9/19/24 with client #18 revealed: -She had been receiving treatment at this facility for the past 20 yearsShe had a new counselor that she met with monthly"Counselors come and go that is the nature of this business." | | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | | SURVEY PLETED |
|--|---------|---|--|-----------------|--|---|------------------|
| MALO32-412 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701 (X4) ID PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FREEDX TAG CONTINUED FROM INSTITUTION OF THE PROVIDER OF THE PROVIDER SPLAN OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) V 235 Continued From page 9 | | | | A. BUILDING. | | | R |
| BAART COMMUNITY HEALTHCARE (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (X5) PREFIX TAG (X6) PREFIX TAG (X6) PREFIX TAG (X6) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (X5) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EAC | | | MHL032-412 | B. WING | | | |
| CALL DURHAM, NC 27701 | NAME OF | PROVIDER OR SUPPLIER | STREET AI | ODRESS, CITY, S | STATE, ZIP CODE | | |
| PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 235 Continued From page 9 -Staff #1 had a caseload of 51 clientsStaff #2 had a caseload of 52 clients163 current clients did not have a counselor assigned. Interview on 9/19/24 with Client #17 revealed: -She had a new counselorThis was the second counselor she had this yearShe met 1 hour monthly with her counselor, but she tried to see her every 2 weeks -"It ry to squeeze my head in every two weeks." -She had come to the point that she did not want to get very close to the counselors as they may leave soon afterShe had no other issues with the facility"I feel well cared for by staff." Interview on 9/19/24 with client #18 revealed: -She had been receiving treatment at this facility for the past 20 yearsShe had a new counselor that she met with monthly"Counselors come and go that is the nature of | BAART | COMMUNITY HEALTH | 1CARE | | STREET, SUITE 300 & 400 | | |
| -Staff #1 had a caseload of 51 clientsStaff #2 had a caseload of 53 clientsThe Director had a caseload of 53 clients163 current clients did not have a counselor assigned. Interview on 9/19/24 with Client #17 revealed: -She had a new counselorThis was the second counselor she had this yearShe met 1 hour monthly with her counselor, but she tried to see her every 2 weeks -"I try to squeeze my head in every two weeks." -She had come to the point that she did not want to get very close to the counselors as they may leave soon afterShe had no other issues with the facility"I feel well cared for by staff." Interview on 9/19/24 with client #18 revealed: -She had been receiving treatment at this facility for the past 20 yearsShe had a new counselor that she met with monthly"Counselors come and go that is the nature of | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T | ON SHOULD BE HE APPROPRIATE | COMPLETE |
| Interview on 9/19/24 with client #19 revealed: -He currently was not assigned a counselorHad been receiving treatment at the facility for the past 2.5 yearsIf he needed to see a counselor, the Director or one of the counselors were available"I don't know why they come and go, need to talk with management about that". Interview on 9/19/24 with Staff #1 revealed: -She had been working at the facility for about 2 months. | V 235 | -Staff #1 had a cas-Staff #2 had a cas-Staff #2 had a cas-The Director had a -163 current clients assigned. Interview on 9/19/2-She had a new coryearShe met 1 hour mashe tried to see her-"I try to squeeze m-She had come to to get very close to leave soon afterShe had no other i-"I feel well cared for Interview on 9/19/2-She had been received for the past 20 yearShe had a new commonthly"Counselors come this business." Interview on 9/19/2-He currently was monthly was not business." Interview on 9/19/2-The needed to see one of the counselors come of the counselors one of the | eload of 51 clients. seload of 51 clients. a caseload of 53 clients. a caseload of 53 clients. b did not have a counselor 4 with Client #17 revealed: unselor. nd counselor she had this onthly with her counselor, but a every 2 weeks ny head in every two weeks." the point that she did not want the counselors as they may bissues with the facility. Or by staff." 4 with client #18 revealed: eiving treatment at this facility rs. unselor that she met with and go that is the nature of 4 with client #19 revealed: not assigned a counselor. g treatment at the facility for e a counselor, the Director or ors were available. they come and go, need to talk about that". 4 with Staff #1 revealed: | | DEI TOIENG | • | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | MHL032-412 | B. WING | | 09/2 | 0/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE | H MANGUM NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 235 | Continued From pa | ge 10 | V 235 | | | |
| | needed. | for other unassigned clients as ts once a month, but reported o do. | | | | |
| | -She had been emp -It has been "very b facility. -She had 51 clients she also covered for counselor as needed -"I do what I can to -Depending on the | help." client, she tried to have at our a month with them. | | | | |
| | -The facility was cu had two counselors -She was in the procounselorsCounselors had be at competitive ager -"It had been a revocunselors. As soo hired, another one she also had two Leave, but when it they quit. This deficiency has the original cite on the third of the counselors. This deficiency is considered to the counselors. As soo hired, another one of the counselors. As soo hired, another one of the counselors. This deficiency is considered to the counselors. This deficiency is considered to the counselors. | een leaving the facility to work ncies in the area. Olving door lately with the n as a counselor would get would leave." counselors on Family Medical was time for them to return, been cited two times since 6/14/21. ross referenced into 10A Outpatient Opioid Treatment - r a Type B rule violation and | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | |
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| | | MHL032-412 | B. WING | | 09/2 | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | CARE | ΓH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORREC | TION | (X5) |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | | COMPLÉTE DATE |
| V 237 | Continued From pa | ge 11 | V 237 | | | |
| V 237 | 27G .3604 (A-D) O | utpt. Opioid - Operations | V 237 | | | |
| | days per week, 12 i weekend and holida hours shall be sche the client. (b) Compliance wit Mental Health Serv or The Center for S (CSAT) Regulations certified by a private agency, that has be of the United State Human Services ar all SAMHSA Opioid Detoxification Treat regulations in 42 Cl incorporated by refe amendments and e available from the C5600 Fishers Lane, no cost. (c) Compliance Wifacility shall be currified Drug Enfor shall be in complian Administration regulations and Drugs, Part 130 incorporated by refe amendments and e available from the Uprinting Office, Waspublished rate. (d) Compliance Wifacility shall be gach facility shall be larger and Drugs, Part 130 incorporated by refe amendments and e available from the Uprinting Office, Waspublished rate. (d) Compliance Wifacility shall be larger and be a solution. | odd OPERATIONS acility shall operate at least six months per year. Daily, ay medication dispensing duled to meet the needs of the Substance Abuse and ices Administration (SAMHSA) aubstance Abuse Treatment as. Each facility shall be a non-profit entity or a State and proved by the SAMHSA Department of Health and and shall be in compliance with Drugs in Maintenance and ment of Opioid Addiction FR Part 8, which are arence to include subsequent ditions. These regulations are CSAT, SAMHSA, Rockwall II, Rockville, Maryland 20857 at the DEA Regulations. Each and provided in 21 C.F.R., Food to the operation of the subsequent ditions. These regulations are codified in 21 C.F.R., Food to the operation of the subsequent ditions. These regulations are considered in the subsequent ditions. These regulations are considered to include subsequent ditions. | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED |
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| | MHL032-412 | D. WING | | 09/2 | 20/2024 |
| PROVIDER OR SUPPLIER | | | | | |
| COMMUNITY HEALTH | CARE | | I STREET, SUITE 300 & 400 | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOU | JLD BE | (X5) COMPLETE DATE |
| DMH/DD/SAS, which the Secretary of He exercise the responstate for governing an opioid drug, inclumonitoring complian related to scope, stamonitoring complian 102-321. The referobtained from the Section of DMH/DD This Rule is not me Based on record refacility management with regulations in an annual physical Addiction affecting #6, #7, #8, #9, #10, are: Review on 9/17/24 -Admission date of -Diagnosis of Opioid Dependence-Uncondocumentation of examination by a pl 7/12/22. Review on 9/18/24 -Admission date of -Diagnosis of Opioid-Documentation of examination by a pl 10/12/21. Review on 9/18/24 -Admission date of -Diagnosis of Opioid-Documentation of examination by a pl 10/12/21. | ch is the person designated by alth and Human Services to asibility and authority within the the treatment of addiction with uding program approval, for nece with the regulations aff, and operations, and for nece with Section 1923 of P.L. enced material may be substance Abuse Services o/SAS. Let as evidenced by: views and interviews, the trailed to assure compliance to treat a service of 2 CFR Part 8 which require during treatment for Opioid of 21 audited clients (#2, #5, #12 and #13). The findings of client #2's record revealed: 10/11/19. In the client's last physical mysician was completed on of client #5's record revealed: 9/19/18. In Dependence-Severe the client's last physical mysician was completed on of client #6's record revealed: 12/19/18. | V 237 | | | |
| | | | | | |
| | PROVIDER OR SUPPLIER COMMUNITY HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa DMH/DD/SAS, which the Secretary of He exercise the responstate for governing an opioid drug, inclumonitoring complian related to scope, sta monitoring complian 102-321. The refer obtained from the Si Section of DMH/DD This Rule is not me Based on record re facility management with regulations in 4 an annual physical Addiction affecting 1 46, #7, #8, #9, #10, are: Review on 9/17/24 -Admission date of -Diagnosis of Opioid Dependence-Uncorely -Documentation of examination by a pl 7/12/22. Review on 9/18/24 -Admission date of -Diagnosis of Opioid -Documentation of examination by a pl 10/12/21. Review on 9/18/24 -Admission date of -Diagnosis of Opioid -Documentation of examination by a pl 10/12/21. Review on 9/18/24 -Admission date of -Diagnosis of Opioid | PROVIDER OR SUPPLIER STREET AD BOO NORT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with the regulations related to scope, staff, and operations, and for monitoring compliance with Section 1923 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services Section of DMH/DD/SAS. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure compliance with regulations in 42 CFR Part 8 which require an annual physical during treatment for Opioid Addiction affecting 9 of 21 audited clients (#2, #5, #6, #7, #8, #9, #10, #12 and #13). The findings are: Review on 9/17/24 of client #2's record revealed: -Admission date of 10/11/19Diagnosis of Opioid Dependence-UncomplicatedDocumentation of the client's last physical examination by a physician was completed on 7/12/22. Review on 9/18/24 of client #5's record revealed: -Admission date of 9/19/18Diagnosis of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on | MHL032-412 B. WING | PROVIDER OR SUPPLIER TOMMUNITY HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with Section 1923 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services Section of DMH/DD/SAS. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure compliance with regulations regulations in 24 CFR Part 8 which require an annual physical during treatment for Opioid Addiction affecting 9 of 21 audited clients (#2, #5, #6, #7, #8, #9, #10, #12 and #13). The findings are: Review on 9/17/24 of client #2's record revealed: -Admission date of 10/11/19Diagnosis of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on 10/12/21. Review on 9/18/24 of client #6's record revealed: -Admission date of 12/19/18Diagnosis of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on 10/12/21. Review on 9/18/24 of client #6's record revealed: -Admission date of 12/19/18Diagnosis of Opioid Dependence-Severe. | MHL032-412 B. WING B. WING B. WING B. WING COMMUNITY HEALTHCARE SOM NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 12 DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with Section 1933 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services Section of DMH/DD/SAS. This Rule is not met as evidenced by; Based on record reviews and interviews, the acility management failed to assure compliance with regulations in 42 CFR Part 8 which require an annual physical during treatment for Opioid Addiction affecting 9 of 21 audited clients (#2, #5, #6, #7, #8, #9, #10, #12 and #13). The findings are: Review on 9/17/24 of client #2's record revealed: -Admission date of 10/11/19Diagnosis of Opioid Dependence-UncomplicatedDocumentation of the client's last physical examination by a physician was completed on 7/12/22. Review on 9/18/24 of client #5's record revealed: -Admission date of 3/19/18Diagnosis of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on 10/12/21. Review on 9/18/24 of client #6's record revealed: -Admission date of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on 10/12/21. Review on 9/18/24 of client #6's record revealed: -Admission date of 3/19/18Diagnosis of Opioid Dependence-SevereDocumentation of the client's last physical examination by a physician was completed on 10/12/21. |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 13 of 32

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------------|---|--------------------------------|-------------------------------|--|
| | | MHL032-412 | B. WING | | | R 20/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART | COMMUNITY HEALTH | ICTARE | RTH MANGUM M, NC 27701 | STREET, SUITE 300 & 400 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| V 237 | Review on 9/18/24 -Admission date of -Diagnosis of Opioi -Documentation of examination by a pl 7/12/23. Review on 9/18/24 -Admission date of -Diagnosis of Opioi -Documentation of examination by a pl 8/2019. Review on 9/17/24 -Admission date of -Diagnosis of Opioi Maintenance Thera -Documentation of examination by a pl 3/21/23. Review on 9/17/24 revealed: -Admission date of -Diagnosis of Opioi Maintenance Thera -Documentation of examination by a pl 3/14/23. Review on 9/18/24 revealed: -Admission date of | hysician was completed on of client #7's record revealed 7/12/23. d Use Disorder- Severe. the client's last physical hysician was completed on of client #8's record revealed 8/20/19. d Use Disorder- Severe. the client's last physical hysician was completed on of client #9's record revealed 8/22/18. d Use Disorder- Severe, On hys. the client's last physical hysician was completed on of client #10's record 3/14/23. d Use Disorder- Severe, On hy. the client's last physical hysician was completed on of client #10's record 3/14/23. d Use Disorder- Severe, On hys. the client's last physical hysician was completed on of client #12's record | l: | | | | |
| | -Documentation of | the client's last physical | | | | | |

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STATE FORM 5899 ZPPL11 If continuation sheet 14 of 32

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | | SURVEY PLETED | | |
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| | | | A. BUILDING: | · | | D | |
| | | MHL032-412 | B. WING | | | R 20/2024 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART (| COMMUNITY HEALTH | HUARE | RTH MANGUN M, NC 27701 | 1 STREET, SUITE 300 & 400 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE | |
| V 237 | Continued From page 14 | | V 237 | | | | |
| | 7/21/20. | | | | | | |
| | revealed: -Admission date of -Diagnosis of Opio -Documentation of examination by a p 5/10/22. | id Use Disorder- Severe. the client's last physical physician was completed on | | | | | |
| | Interview on 9/17/24 with the Director revealed: -She attributed missing physicals to being understaffed at the facilityShe acknowledged that annual physicals were not completed for clients #2, #5, #6, #7, #8, #9, #10, #12 and #13. | | | | | | |
| | This deficiency has the original cite on | s been cited two times since 6/14/21. | | | | | |
| | NCAC 27G .3601 (| cross referenced into 10A Outpatient Opioid Treatment - or a Type B rule violation and within 45 days. | | | | | |
| V 238 | 27G .3604 (E-K) O | outpt. Opioid - Operations | V 238 | | | | |
| | TREATMENT - OP (e) The State Auth approval on the foli (1) complian law and regulations (2) complian standards of practi (3) program service delivery; ar (4) impact or | nority shall base program lowing criteria: uce with all state and federal s; uce with all applicable ce; structure for successful | | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 15 of 32

| STATEMENT OF DEFICIENCIES (Y4) PROVIDER/SUBBLIER/CLIA | | ()(0) 1 | E CONCEDITORIONI | 1000 - : | OLID. (E.) (| |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE | |
| VIAD LEWIN | OI OOMALOTION | IDENTIFICATION NUMBER. | A. BUILDING: | | COIVIPI | |
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| | | MHL032-412 | B. WING | | 1 | 0/2024 |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE 800 NORT | TH MANGUM | I STREET, SUITE 300 & 400 | | |
| DAAITI | JOHN JOHN THEALTH | DURHAM | , NC 27701 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| PRÉFIX | | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | , | | |
| V 238 | Continued From pa | ge 15 | V 238 | | | |
| | (f) Take-Home Elig | ibility. Any client in | | | | |
| | | intenance treatment who | | | | |
| | requests unsupervi | sed or take-home use of | | | | |
| | methadone or other | r medications approved for | | | | |
| | | addiction must meet the | | | | |
| | | ents for time in continuous | | | | |
| | treatment. The clie | nt must also meet all the | | | | |
| | requirements for co | ontinuous program compliance | | | | |
| | and must demonstr | ate such compliance during | | | | |
| | the specified time p | eriods immediately preceding | | | | |
| | any level increase. | In addition, during the first | | | | |
| | year of continuous | treatment a patient must | | | | |
| | | of two counseling sessions per | | | | |
| | | st year and in all subsequent | | | | |
| | | s treatment a patient must | | | | |
| | attend a minimum om om month. | of one counseling session per | | | | |
| | (1) Levels of following conditions | Eligibility are subject to the | | | | |
| | (A) Level 1. [| During the first 90 days of | | | | |
| | continuous treatme | nt, the take-home supply is | | | | |
| | limited to a single d | ose each week and the client | | | | |
| | shall ingest all othe the clinic; | r doses under supervision at | | | | |
| | , | After a minimum of 90 days of | | | | |
| | ` ' | n compliance, a client may be | | | | |
| | | num of three take-home doses | | | | |
| | , • | other doses under supervision | | | | |
| | at the clinic each w | | | | | |
| | | After 180 days of continuous | | | | |
| | | nimum of 90 days of | | | | |
| | | n compliance at level 2, a | | | | |
| | | ed for a maximum of four | | | | |
| | | nd shall ingest all other doses | | | | |
| | | at the clinic each week; | | | | |
| | | After 270 days of continuous | | | | |
| | | nimum of 90 days of | | | | |
| | | n compliance at level 3, a | | | | |
| | | ed for a maximum of five | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLE | |
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| l sumus | /2024 |
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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| 800 NORTH MANGUM STREET, SUITE 300 & 400 | |
| BAART COMMUNITY HEALTHCARE DURHAM, NC 27701 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| V 238 Continued From page 16 V 238 | |
| take-home doses and shall ingest all other doses under supervision at the clinic each week; (E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F) Level 6. After two years of continuous treatment and a minimum of no year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month. (2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility: (A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility suspended; and (C) The reinstatement of take-home eligibility; (B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and (C) The reinstatement of take-home eligibility is reduced or freatment Program. (3) Exceptions to Take-Home Eligibility: (A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COME | SURVEY PLETED | | | |
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| | | MHL032-412 | 2 | B. WING | | I | 20/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART | COMMUNITY HEALTH | CARE | 800 NORT | TH MANGUM | STREET, SUITE 300 & 400 | | | |
| | - | | DURHAM | , NC 27701 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| | personal or family of may be permitted a by the State authorifound to be response Except in instances verifiable physical of 13 take-home do period during the first treatment. | temporarily reductive, provided she consible in handling of involving a client lisability, there is a consess allowable in a set two years of consess all years allowable in a set two years of consess allowable in a set twhich years allowable in a set two years allowable in a set two ye | ced schedule or he is also opioid drugs. with a a maximum any two-week ontinuous | | | | | |
| | applicable mandator verifiable physical of additional take-hom authority. Clients we take-home eligibility disability may be gr 30-day supply of tal make monthly clinic (4) Take-Hom Take-home dosage medications approvaddiction shall be a physician on an induct to the following: (A) An addition methadone or other treatment of opioid to each eligible client treatment) for each | lisability may be pose eligibility by the religibility by the religibility by the religible anted up to a maximum and the religible anted up to a maximum and the religible anted up to a maximum and the religible and the religibl | use of a permitted State dditional le physical kimum ion and shall dolidays: or other ent of opioid acility s according ly of proved for the dispensed ime in supply of proved for the dispensed | | | | | |
| | restriction shall not receiving take-hom above. (g) Withdrawal Fro Opioid Treatment. withdrawal from me | apply to clients w e medications at l m Medications Fo The risks and ber | ho are Level 4 or or Use In nefits of | | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | MHL032-412 | B. WING | | F 09/2 | R 0/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS CITY S | STATE, ZIP CODE | 03/2 | 0/2024 |
| I BAARI COMMINILY HEALTHCARE | | | | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 238 | approved for use in discussed with each treatment and annu. (h) Random Testin and other drugs share active opioid treatment one random drug to treatment. Addition three-month period treatment episode, will be observed by to include at least the methadone, cocain amphetamines, The alcohol. Alcohol testing by either urinalysis, alternate scientifica (i) Client Discharge be discharged from dependent upon mapproved for use in client is provided that the drug. (j) Dual Enrollment outpatient opioid act which dispense Me Levo-Alpha-Acetyl-pharmacological action subsequer required to participal Registry or ensure enrolled by means exchange with all owithin at least a 75-program. Program participate in a communication and wanagement and wanagement and wanagement and wanagement and wanagement and within at least a 75-program. Program participate in a communication and wanagement and wanag | opioid treatment shall be h client at the initiation of lally thereafter. g. Random testing for alcohol all be conducted on each lent client with a minimum of est each month of continuous lally, in two out of each of a client's continuous at least one random drug test program staff. Drug testing is ne following: opioids, e, barbiturates, C, benzodiazepines and sting results can be gathered breathalyzer or other lly valid method. Restrictions. No client shall the facility while physically ethadone or other medications opioid treatment unless the e opportunity to detoxify from a Prevention. All licensed ediction treatment facilities thadone, Methadol (LAAM) or any other gent approved by the Food and a for the treatment of opioid ent to November 1, 1998, are late in a computerized Central that clients are not dually of direct contact or a list pioid treatment programs emile radius of the admitting is are also required to | V 238 | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BOILDING. | | R | |
| | | MHL032-412 | B. WING | | 1 | 0/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAARI COMMUNITY HEALTHCARE | | | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 238 | State Authority for (k) Diversion Control (k) Diversion Control Opioid Treatment Frequired to establis control plan as part shall document the procedures. A diverthe following element (1) dual enrous that consist of client program contacts, pregistry or list exchange (2) call-in's foor solid dosage form (3) call-in's foor solid dosage form (3) call-in's foor solid dosage form (4) drug testing review of the levels medications approvaddiction; (5) client atternal control of the contr | Opioid Treatment. Fol Plan. Outpatient Addiction Programs in North Carolina are the and maintain a diversion of program operations and plan in their policies and rsion control plan shall include ints: Ilment prevention measures the consents, and either coarticipation in the central langes; or bottle checks, bottle returns in call-in's; or drug testing; or gresults that include a of methadone or other and of the treatment of opioid indance minimums; and the set of ensure that clients | V 238 | | | |
| | This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to A) ensure during the first year of continuous treatment, clients attend a minimum of two counseling sessions a month affecting 1 of 21 audited clients (#3); B) after the first year and in all subsequent years of continuous treatment a client attend at least one counseling session per month affecting 12 of 21 audited clients (#1, #2, #4, #5, #7. #8. #9, #10, #12, #13, #14 and #15); and C) failed to ensure counseling sessions were completed after a positive Urine Drug Screen (UDS) affecting 7 of 21 audited clients (#2, #3, #4, #7, #8, #10 and #12). The findings are: | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | . , | SURVEY PLETED | |
|--------------------------|---|--|----------------------------|--|-----------------------------------|--------------------------|--|
| | | | A. BUILDING | · | | | |
| | | MHL032-412 | B. WING | | | R 20/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, | STATE, ZIP CODE | | | |
| BAART | COMMUNITY HEALTH | 1CARE | RTH MANGUN AM, NC 27701 | I STREET, SUITE 300 & 40 | 0 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| V 238 | 1 3 | | V 238 | | | | |
| | -Admission date of -Diagnosis of Opioi Maintenance Thera -In the last 6 month sessions for the mo -There was no cour since 5/1/24. | id Use Disorder- Severe on apy. ns, there were no counseling onths of June, July and Augus nseling session completed | st. | | | | |
| | Review on 9/17/24 of client #2's record revealed: -Admission date of 10/11/19Diagnosis of Opioid Dependence-UncomplicatedIn the last 6 months, there were no counseling sessions for the months of March. April. June. | | i: | | | | |
| | sessions for the months of March, April, June, July and AugustUDS conducted on 5/17/24 indicated positive findings for amphetamines, benzodiazepines, cocaine, marijuana and fentanylThe client failed to screen on four different attempts for the month of June. | | | | | | |
| | -UDS conducted on 7/15/24 indicated positive findings for amphetamines, marijuana, cocaine and fentanylUDS conducted on 8/15/24 indicated positive findings for amphetamines, marijuana, cocaine, fentanyl and opiatesThere were no counseling sessions to address the positive UDS from 7/15/24 and 8/15/24. | | | | | | |
| | Review on 9/17/24 -Admission date of -Diagnosis of Opioi -In the last 6 month sessions for the mo June, July and Aug -Client #3 did not re sessions per month | of client #3's record revealed 1/2/24. id Use Disorder- Severe. ns, there were no counseling onths of March, April, May, just. eceive two counseling h. n 6/10/24 indicated positive | l: | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 21 of 32

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED | |
|--|--|--|---|--|----------------------------------|--------------------------|
| | | MHL032-412 | B. WING | B. WING 09/2 | | |
| | PROVIDER OR SUPPLIER | ICARE 800 NO | ADDRESS, CITY, S RTH MANGUM M, NC 27701 | TATE, ZIP CODE STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 238 | -UDS conducted or findings for opiates -UDS conducted or finding for fentanylThere were no couthe positive UDS from Review on 9/17/24 -Admission date of -Diagnosis of Opioi Maintenance Thera -In the last 6 month sessions for the moduly and AugustUDS conducted or findings for amphet -UDS cond | an 7/5/24 indicated positive and fentanyl. In 8/6/24 indicated positive inseling sessions to address om 6/10/24, 7/5/24 and 8/6/24 of client #4's record revealed 6/6/17. In the discrete of t | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 22 of 32

| DIVISION | of Health Service Re | egulation | | | | |
|----------------------------|------------------------------|--|--------------|--|-------------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | · | COMP | LETED |
| | | | | | F | , |
| | | MHL032-412 | B. WING | | 09/20/2024 | |
| | | • | | | 1 00/2 | 0/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| BAARI COMMUNITY HEALTHCARE | | | | I STREET, SUITE 300 & 400 | | |
| | DURHAN | | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | | COMPLETE DATE |
| IAG | TREGOE TOTAL | | TAG | DEFICIENCY) | 1 (I) (I) L | |
| 1/000 | 0 " 15 | | 1/ 000 | | | |
| V 238 | Continued From pa | age 22 | V 238 | | | |
| | -UDS conducted or | n 6/5/24 indicated positive | | | | |
| | findings for opiates. | | | | | |
| | -There was no cour | nseling session to address the | е | | | |
| | positive UDS from 6 | | | | | |
| | Review on 9/18/24 | of client #8's record revealed | | | | |
| | -Admission date of | | | | | |
| | | id Use Disorder- Severe. | | | | |
| | | ns, there were no counseling | | | | |
| | | onths of March, April, May, | | | | |
| | June and August. | 7/47/04: 1: 4 1 ::: | | | | |
| | | n 7/17/24 indicated positive | | | | |
| | | liazepines and marijuana. | | | | |
| | finding for benzodia | n 8/15/24 indicated positive | | | | |
| | | unseling sessions to address | | | | |
| | the positive UDS fro | | | | | |
| | the positive obe in | OIII 0/10/24. | | | | |
| | | of client #9's record revealed | : | | | |
| | -Admission date of | | | | | |
| | | id Use Disorder- Severe, On | | | | |
| | Maintenance Thera | | | | | |
| | | ns, there were no counseling onths of April, June and | | | | |
| | August. | onins of April, June and | | | | |
| | 0 | nseling session completed | | | | |
| | since 7/15/24. | nselling describin completed | | | | |
| | Deview e- 0/47/04 | of align# #40la | | | | |
| | | of client #10's record | | | | |
| | revealed: -Admission date of | 2/14/22 | | | | |
| | | id Use Disorder- Severe, On | | | | |
| | Maintenance Thera | | | | | |
| | | apy. ns, there were no counseling | | | | |
| | | onths of May, June and | | | | |
| | August. | or maj, dand and | | | | |
| | | n 7/9/24 indicated positive | | | | |
| | | e, opiates, marijuana and | | | | |
| | fentanyl. | , , , , , , , , , , , , , , , , , , , | | | | |
| | | n 8/26/24 indicated positive | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 23 of 32

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | | SURVEY PLETED | | |
|--|---|--|--|-------------------------|---|-----------|--------------------------|
| | | | | A. BUILDING: | | | n |
| | | MHL032- | 412 | B. WING | | | R 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE | | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | | ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 238 | findings for cocaine -UDS conducted or findings for cocaine -There were no cou the positive UDS fr Review on 9/18/24 revealed: -Admission date of -Diagnosis of Opioi -In the last 6 month sessions for the mo -There was no cou since 6/3/24UDS conducted or findings for marijua -UDS conducted or findings for cocaine -UDS conduct | e, fentanyl and on 9/3/24 indicated, fentanyl and ourseling session om 7/9/24, 8/26 of client #12's range of the property of t | ed positive opiates. Ins to address 6/24 and 9/3/24. Insecord Inse | V 238 | | | |
| | Review on 9/18/24 revealed: -Admission date of -Diagnosis of Opioi-In the last 6 month | 8/29/17. d Use Disorder | - Severe. | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 24 of 32

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|-------------------------|--|------------------------------|-------------------------------|--|
| | | | | A. BOILDING. | | | R | |
| | | MHL03 | 2-412 | B. WING | | | 20/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART (| COMMUNITY HEALTH | ICARE | | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC' REGULATORY OR L | | CEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| V 238 | Continued From pa | ige 24 | | V 238 | | | | |
| | sessions for the mo | onths of June | and July. | | | | | |
| | Review on 9/18/24 revealed: -Admission date of -Diagnosis of Opioi-There was no cou since 4/24/24. Interview on 9/19/2-She had a new co-She met 1 hour m she tried to see the weeks. | 2/22/12. d Use Disord nseling session 4 with client # unselor. onthly with he | ler- Severe. on completed #17 revealed: er counselor, but | | | | | |
| | Interview on 9/19/24 with client #18 revealed: -She had been receiving treatment at this facility for the past 20 yearsShe had a new counselor that she met with monthly. | | | | | | | |
| | Interview on 9/19/2 -He currently was r -Had been receivin past 2.5 yearsIf he needed to se one of the counselo | not assigned a g treatment a e a counselo | a counselor. at facility for the | | | | | |
| | Interview on 9/19/2 -The facility was cu-"Having only two of made it difficult to ecounselors." - She confirmed the counseling session positive Urine Drug #3, #4, #7, #8, #10 This deficiency con | errently under counselors an ensure clients e facility failed s were comp Screen (UD) and #12. | staffed. Id myself, have Is are seen by Id to ensure Ileted after a S) for clients #2, | | | | | |
| | 25115151109 501 | | | | | | | |

Division of Health Service Regulation STATE FORM

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------------|--|-------------------------------|------------------|
| | | | | | | R |
| | | MHL032-412 | B. WING | | 09/2 | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | STATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | CARE | TH MANGUM I, NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | | (X5) |
| PRÉFIX TAG | | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | E APPROPRIATE | COMPLETE DATE |
| V 238 | Continued From pa | ge 25 | V 238 | | | |
| | NCAC 27G .3601 C | ross referenced into 10A Outpatient Opioid Treatment - r a Type B rule violation and within 45 days. | | | | |
| V 536 | 27E .0107 Client Ri Int. | ghts - Training on Alt to Rest. | V 536 | | | |
| | practices that emph to restrictive interve (b) Prior to providir disabilities, staff incompletes, student demonstrate compete completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agency based on state compound compliance and degathered. (d) The training shall include measurable measurable testing behavior) on those methods to determic course. (e) Formal refreshed by each service programually). (f) Content of the training wishes to determine the course of the provider wishes to design the provider wishes the provider | mplement policies and nasize the use of alternatives entions. In services to people with eluding service providers, as or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or | | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|--|-------------------------------|--------------------------|
| | | | | | R | |
| MHL032-412 | | B. WING | | 09/2 | 0/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | ICARE | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| V 536 | Paragraph (g) of th (g) Staff shall dem following core area: (1) knowledg people being serve (2) recognizing behavior; (3) recognizing external stressors to disabilities; (4) strategies relationships with p (5) recognizing organizational factor disabilities; (6) recognizing assisting in the personal decisions about the (7) skills in assisting behavior (8) communication of the strategies or should be secalating behavior (8) communication of the strategies or should be should be secalating personal decisions about the communication of the strategies or should be | is Rule. constrate competence in the s: e and understanding of the d; ng and interpreting human ng the effect of internal and hat may affect people with efor building positive ersons with disabilities; ng cultural, environmental and ors that may affect people with ng the importance of and son's involvement in making sir life; essessing individual risk for | V 536 | | | |
| | means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: | | | | | |

Division of Health Service Regulation

STATE FORM 6899 ZPPL11 If continuation sheet 27 of 32

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|---|--|---|---------------------|--|-----------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | MHL032-412 | B. WING | | 09/2 | R 10/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DAADT | COMMUNITY HEALTH | 800 NORT | H MANGUM | STREET, SUITE 300 & 400 | | |
| DAANI | COMMONITY HEALTH | DURHAM, | NC 27701 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 536 | Continued From pa | ge 27 | V 536 | | | |
| | (1) Trainers so by scoring 100% or aimed at preventing need for restrictive (2) Trainers so by scoring a passin instructor training posservation of behaviors and competency-based objectives, measurable method failing the course. (4) The contest service provider plate approved by the Divito Subparagraph (i) (5) Acceptable shall include but are (A) understand (B) methods course; (C) methods performance; and (D) document (6) Trainers so teaching a training reducing and elimin interventions at lease review by the coach (7) Trainers so aimed at preventing need for restrictive annually. (8) Trainers so instructor training and (j) Service provider | shall demonstrate competence in testing in a training program greducing and eliminating the interventions. In the shall demonstrate competence grade on testing in an arogram. In shall be griculate measurable learning able testing (written and by avior) on those objectives and disto determine passing or an ent of the instructor training the ansito employ shall be avision of MH/DD/SAS pursuant (5) of this Rule. It is instructor training programs are not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee In the shall have coached experience program aimed at preventing, atting the need for restrictive atting the need for restrictive atting the and eliminating the interventions at least once Is shall complete a refresher theast every two years. The shall maintain antitial and refresher instructor | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|---|---|------------------------------|-------------------------------|--|
| | | | | A. BUILDING: | | | _ | |
| | | MHL03 | 2-412 | B. WING | | | R 20/2024 | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| BAART (| COMMUNITY HEALTH | ICARE | | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC) REGULATORY OR L | TEMENT OF DEF MUST BE PREC SC IDENTIFYING | EDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| V 536 | (1) Document (A) who particular outcomes (pass/fai (B) when and (C) instructor (2) The Division request and review (k) Qualifications of (1) Coaches requirements as a (2) Coaches the course which is | mentation shabipated in the l); d where attendished in the look of MH/DE this document Coaches: shall meet all trainer. shall teach at being coaches shall demonstrainer of coaches thall demonstrainer. | training and the ded; and D/SAS may ntation any time. I preparation t least three times ed. strate paching or | V 536 | | | | |
| | This Rule is not me Based on record re facility failed to ens training in alternative for 5 of 5 audited so Director, the Nurse findings are: | views and int ure that all st ves to restricti taff (Staff #1, | terviews, the aff completed ive intervention Staff #2, the | | | | | |
| | Review on 9/18/24 revealed: -She was hired on -She was hired as -Relias online traini -7/17/24 North | 7/18/24. a Counselor. ng: | personnel record | | | | | |

Division of Health Service Regulation

| | DATE SURVEY COMPLETED |
|--|--------------------------|
| | R |
| MHL032-412 B. WING | 09/20/2024 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| BAART COMMUNITY HEALTHCARE 800 NORTH MANGUM STREET, SUITE 300 & 400 DURHAM, NC 27701 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG DEFICIENCY) | (X5) COMPLETE DATE |
| of Seclusion and Restraint, and Use of Safety Interventions. 1.25 of training hours. -There was no documentation of "Relias Crisis Prevention and Protective Interventions Program" and no instructor identified. -There was no confirmation from Relias of specific modules of training or the instructor training requirements, who would verify competencies. Review on 9/18/24 of Staff #2's personnel record revealed: -She was hired on 2/5/24She was hired as a CounselorRelias online training: -2/27/24- North Carolina Rules for Prevention of Sectusion and Restraint, and Use of Safety Interventions. 1.25 of training hoursThere was no documentation of "Relias Crisis Prevention and Protective Interventions Program" and no instructor identifiedThere was no confirmation from Relias of specific modules of training or the instructor training requirements, who would verify competencies. Review on 9/18/24 of the Nurse's personnel record revealed: -She was hired as a Dispensing NurseRelias online training: -6/28/24- North Carolina Rules for Prevention of Seclusion and Restraint, and Use of Safety Interventions. 1.25 of training hoursThere was no documentation of "Relias Crisis Prevention and Protective Interventions Program" and no instructor identifiedThere was no documentation of "Relias Crisis Prevention and Protective Interventions Program" and no instructor identifiedThere was no confirmation from Relias of specific modules of training norms. | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 30 of 32

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ′ | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED | |
|---|---|--|--|-------------------------|--|----------------------------------|--------------------------|
| | | | | A. BOILDING. | | | R |
| | | MHL032-412 | | B. WING | | | 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| BAART (| COMMUNITY HEALTH | ICARE | | TH MANGUN , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 536 | Continued From pa | age 30 | | V 536 | | | |
| | competencies. | | | | | | |
| | record revealed: -She was hired on -She was hired as -Relias online train: -7/10/24- North of Seclusion and R Interventions. 1.25 -There was no doc Prevention and Pro and no instructor ic -There was no con specific modules of | the Lead Nurse. ing: In Carolina Rules for estraint, and Use of of training hours. umentation of "Relia | Prevention Safety as Crisis s Program" s of | | | | |
| | record revealed: -She was hired on -She was hired as OperationsRelias online train: -12/26/24- Nor Prevention of Sector of Safety Interventi -There was no doc Prevention and Proand no instructor ic -There was no conspecific modules of training requirement competencies. | the Regional Directoring: th Carolina Rules fousion and Restraint, ons. 1.25 of training umentation of "Reliabtective Interventions lentified. firmation from Reliaf f training or the instrate, who would verify 4 with the Director releted online only. | or and Use hours. as Crisis as Program" as of cuctor | | | | |
| | -There was not an | i live session. instructor available t npleting the course. | | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZPPL11 If continuation sheet 31 of 32

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|-------------------------|--|--------------------------------|--------------------------|
| | | MHL032-412 | B. WING | | | R 20/2024 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| BAART | COMMUNITY HEALTH | ICARE | TH MANGUM , NC 27701 | STREET, SUITE 300 & 400 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| V 536 | -There was not an incertificate once the verify staff's comper Interview on 9/19/2 revealed: -She had been infor Resources director the curriculum they-She would review. | instructor signing the course was completed to tencies. 4 with the Regional Director rmed by her Human that the state had approved were using. approved curriculums in the lina and register staff from the | V 536 | | | |