STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-412	A. BUILDING: _____ B. WING _____	R 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

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on September 20, 2024. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP) and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment (SACOT). This facility has a current census of 318 for .3600 Outpatient Opioid Treatment. The .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 0 and the .4500 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) has a current census of 0. The survey sample consisted of audits of 15 current clients and 1 deceased client.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan;	V 113		

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V 113	Continued From page 1 (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain required documentation in the client records affecting 4 of 21 audited clients (#2, #3, #7 and #8). The findings are: Review on 9/17/24 of client #2's record revealed: -Admission date of 10/11/19. -Diagnosis of Opioid Dependence-Uncomplicated.	V 113		

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V 113	Continued From page 2 -There was no signed statement from the client granting permission to seek emergency care from a hospital or physician. Review on 9/17/24 of client #3's record revealed: -Admission date of 1/2/24. -Diagnosis of Opioid Use Disorder- Severe. -There was no signed statement from the client granting permission to seek emergency care from a hospital or physician. Review on 9/18/24 of client #7's record revealed: -Admission date of 7/12/23. -Diagnosis of Opioid Use Disorder- Severe. -There was no signed statement from the client granting permission to seek emergency care from a hospital or physician. Review on 9/18/24 of client #8's record revealed: -Admission date of 8/20/19. -Diagnosis of Opioid Use Disorder- Severe. -There was no signed statement from the client granting permission to seek emergency care from a hospital or physician. Interview on 9/20/24 with staff #2 revealed: -She completed the admission documentation with clients on her caseload. -She was not aware of the emergency medical consent form. -"This is my first time seeing this form." Interviews on 9/20/24 with the Director revealed: -All consents should be completed during the admission process. -The counselors were not aware the emergency medical care consent existed. -This consent was supposed to be a part of the admission package. -The facility failed to maintain completed records	V 113		

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V 113	Continued From page 3 for clients #2, #3, #7 and #8.	V 113		
V 233	27G .3601 Outpt. Opiod Tx. - Scope 10A NCAC 27G .3601 SCOPE (a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. (b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual. (c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days. (d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels.	V 233		

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V 233	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide services designed to affect constructive changes in the client's lifestyle by using methadone in conjunction with the provision of rehabilitation and medical services affecting 13 of 21 audited clients (#1, #2, #3, #4, #5, #7, #8, #9, #10, #12, #13, #14, and #15). The findings are: Cross Reference: 10A NCAC 27G .3603, STAFF (Tag 235) Based on interview and record review, the facility failed to have a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients. Cross Reference: 10A NCAC 27G .3604, OUTPATIENT OPIOID TREATMENT - OPERATIONS (Tag 237). 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). Cross Reference: 10A NCAC 27G .3604, OUTPATIENT OPIOID TREATMENT - OPERATIONS (Tag 238). 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	V 233		

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V 233	Continued From page 5	V 233		

completed after a positive Urine Drug Screen (UDS) affecting 7 of 21 audited clients (#2, #3, #4, #7, #8, #10 and #12).

Review on 9/20/24 of the Plan of Protection dated 9/20/24 written by the Treatment Center Director (TCD) revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
V233
-BAART Durham (facility) will do the following to address deficiencies:
-All staff will be hired within 45 days. There will be a training plan created for all onboarding staff on documentation. Regional Director Operations (RDO) and TCD will train medical assistant on 9/23 and will begin scheduling physicals/annuals. There will be a weekly meeting with the Clinical Team and Medical to ensure compliance. TCD will be meeting with patients to gather their thoughts and needs.
V235
-BAART Durham (facility) agrees to do the following to address deficiencies:
-Continue to advertise via all job boards.
-TCD will review [Licensee Parent Company's Staffing Agency] daily for qualified applicants.
-TCD will schedule interviews for qualified applicants within 24 hours.
-Offers will be made utilizing the current market analysis provided by [Parent Company's Human Resources] (HR).
-All qualified applicants will be onboarded within 2 weeks of accepting offer.
V237
-Director will run services due report every month to identify patients due for physicals.
-Medical assistant will contact and schedule patients due for annual physicals.
-Medical Doctor (MD) and Physician Assistant

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V 233	Continued From page 6 (PA) will need to ensure that physicals are completed and documented in a timely manner. V238 -All vacant Counseling positions will be filled within 45 days. -Counseling Supervisor has been hired and will provide supervision to counselors regarding documentation. -All Counselors will receive training on proper documentation and timelines for completion. -BAART Durham (facility) will follow State Protocols- 2x/month for 1st year and 1x/month there after. Describe your plans to make sure the above happens: V233 -RDO and TCD will meet weekly to review plans and monitor progress. -RDO and TCD will address any deficient areas and provide training and additional support as needed. V235 -RDO will meet with TCD weekly to review hires and process. -TCD will inform RDO of any approved applicants. -RDO will continue to meet with recruiting team weekly regarding vacancies. V237 -Medical Assistant will call all patients the day before to remind of appointment for physicals. -Lead nurse will follow up with Medical Assistant to ensure that patients have been scheduled and physicals completed. -TCD will meet with Lead Nurse to review scheduled appointments and ensure compliance with patients completing annual physicals. V238 -Counselor Supervisor is required to complete monthly audits of patient charts.	V 233		

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V 233	Continued From page 7 -Counselors will complete peer audits monthly. -TCD will complete 10 random chart audits per month. -All of this is to ensure compliance with Documentation and Chart Audits." The facility served adult clients who received outpatient methadone treatment for opioid use disorder. The census at the time of the survey was 318 clients. Only two Counselors and the Director were available to counsel clients. Staff #1 and #2 had a caseload of 51 clients each and the Director had a caseload of 53 clients. 163 clients did not have a counselor assigned. 13 of the 16 clients audited did not receive monthly counseling sessions as required and 7 of the 21 clients audited did not receive counseling to address their positive Urine Drug Screens. The facility failed to comply with the State Opioid Treatment Authority (SOTA), the Substance Abuse and Mental Health Services Administration (SAMHSA) or Drug Enforcement Administration (DEA) standards of annual physical exams that were not completed for 9 of the 21 clients audited. Being understaffed rendered the clinic unable to meet the complex needs of clients to assist in treatment for their substance use/misuse. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 233		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be	V 235		

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V 235	Continued From page 8 on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients. The findings are: Review on 9/17/24 of facility records revealed: -The facility had a census of 318 clients. -The facility had two full time substance abuse counselors and a Director.	V 235		

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V 235	Continued From page 9 -Staff #1 had a caseload of 51 clients. -Staff #2 had a caseload of 51 clients. -The Director had a caseload of 53 clients. -163 current clients did not have a counselor assigned. Interview on 9/19/24 with Client #17 revealed: -She had a new counselor. -This was the second counselor she had this year. -She 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 after. -She 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 years. -She had a new counselor that she met with monthly. -"Counselors come and go that is the nature of this business." Interview on 9/19/24 with client #19 revealed: -He currently was not assigned a counselor. -Had been receiving treatment at the facility for the past 2.5 years. -If 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. -Her current caseload was 51 clients.	V 235		

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V 235	Continued From page 10	V 235		

-She also covered for other unassigned clients as needed.
-She met with clients once a month, but reported that it was difficult to do.

Interview on 9/19/24 with Staff #2 revealed:
-She had been employed for about 7 months.
-It has been "very busy" during her time at the facility.
-She had 51 clients on her current caseload, but she also covered for clients that did not have a counselor as needed.
-"I do what I can to help."
-Depending on the client, she tried to have at least one contact hour a month with them.
-"It does not always happen."

Interview on 9/17/24 with the Director revealed:
-The facility was currently under staffed. She only had two counselors and herself.
-She was in the process of hiring more counselors.
-Counselors had been leaving the facility to work at competitive agencies in the area.
-"It had been a revolving door lately with the counselors. As soon as a counselor would get hired, another one would leave."
-She also had two counselors on Family Medical Leave, but when it was time for them to return, they quit.

This deficiency has been cited two times since the original cite on 6/14/21.

This deficiency is cross referenced into 10A NCAC 27G .3601 Outpatient Opioid Treatment - Scope (Tag 233) for a Type B rule violation and must be corrected within 45 days.

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V 237	Continued From page 11	V 237		
V 237	27G .3604 (A-D) Outpt. Opioid - Operations 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday medication dispensing hours shall be scheduled to meet the needs of the client. (b) Compliance with The Substance Abuse and Mental Health Services Administration (SAMHSA) or The Center for Substance Abuse Treatment (CSAT) Regulations. Each facility shall be certified by a private non-profit entity or a State agency, that has been approved by the SAMHSA of the United State Department of Health and Human Services and shall be in compliance with all SAMHSA Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction regulations in 42 CFR Part 8, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the CSAT, SAMHSA, Rockwall II, 5600 Fishers Lane, Rockville, Maryland 20857 at no cost. (c) Compliance With DEA Regulations. Each facility shall be currently registered with the Federal Drug Enforcement Administration and shall be in compliance with all Drug Enforcement Administration regulations pertaining to opioid treatment programs codified in 21 C.F.R., Food and Drugs, Part 1300 to end, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the United States Government Printing Office, Washington, D.C. 20402 at the published rate. (d) Compliance With State Authority Regulations. Each facility shall be approved by the North Carolina State Authority for Opioid Treatment,	V 237		

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V 237	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 10/11/19. -Diagnosis of Opioid Dependence-Uncomplicated. -Documentation 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 9/19/18. -Diagnosis of Opioid Dependence-Severe. -Documentation 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 12/19/18. -Diagnosis of Opioid Dependence-Severe. -Documentation of the client's last physical	V 237		

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V 237	Continued From page 13 examination by a physician was completed on 12/19/18. Review on 9/18/24 of client #7's record revealed: -Admission date of 7/12/23. -Diagnosis of Opioid Use Disorder- Severe. -Documentation of the client's last physical examination by a physician was completed on 7/12/23. Review on 9/18/24 of client #8's record revealed: -Admission date of 8/20/19. -Diagnosis of Opioid Use Disorder- Severe. -Documentation of the client's last physical examination by a physician was completed on 8/2019. Review on 9/17/24 of client #9's record revealed: -Admission date of 8/22/18. -Diagnosis of Opioid Use Disorder- Severe, On Maintenance Therapy. -Documentation of the client's last physical examination by a physician was completed on 3/21/23. Review on 9/17/24 of client #10's record revealed: -Admission date of 3/14/23. -Diagnosis of Opioid Use Disorder- Severe, On Maintenance Therapy. -Documentation of the client's last physical examination by a physician was completed on 3/14/23. Review on 9/18/24 of client #12's record revealed: -Admission date of 7/21/20. -Diagnosis of Opioid Use Disorder- Severe. -Documentation of the client's last physical examination by a physician was completed on	V 237		

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V 237	Continued From page 14 7/21/20. Review on 9/18/24 of client #13's record revealed: -Admission date of 5/16/22. -Diagnosis of Opioid Use Disorder- Severe. -Documentation of the client's last physical examination by a physician was completed on 5/10/22. Interview on 9/17/24 with the Director revealed: -She attributed missing physicals to being understaffed at the facility. -She acknowledged that annual physicals were not completed for clients #2, #5, #6, #7, #8, #9, #10, #12 and #13. This deficiency has been cited two times since the original cite on 6/14/21. This deficiency is cross referenced into 10A NCAC 27G .3601 Outpatient Opioid Treatment - Scope (Tag 233) for a Type B rule violation and must be corrected within 45 days.	V 237		
V 238	27G .3604 (E-K) Outpt. Opioid - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOID TREATMENT - OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population.	V 238		

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V 238	Continued From page 15 (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month. (1) Levels of Eligibility are subject to the following conditions: (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic; (B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week; (C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week; (D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five	V 238		

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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 one 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 by one level of 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 shall be determined by each Outpatient Opioid Treatment 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 exceptional circumstances such as illness,

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personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment.

(B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits.

(4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following:

(A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday.

(B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above.

(g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications

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approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter.
(h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method.
(i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug.
(j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina

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V 238	Continued From page 19 State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction; (5) client attendance minimums; and (6) procedures to ensure that clients properly ingest medication. 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:	V 238		

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Review on 9/17/24 of client #1's record revealed:
-Admission date of 1/2/19.
-Diagnosis of Opioid Use Disorder- Severe on Maintenance Therapy.
-In the last 6 months, there were no counseling sessions for the months of June, July and August.
-There was no counseling session completed since 5/1/24.

Review on 9/17/24 of client #2's record revealed:
-Admission date of 10/11/19.
-Diagnosis of Opioid Dependence-Uncomplicated.
-In the last 6 months, there were no counseling sessions for the months of March, April, June, July and August.
-UDS conducted on 5/17/24 indicated positive findings for amphetamines, benzodiazepines, cocaine, marijuana and fentanyl.
-The 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 fentanyl.
-UDS conducted on 8/15/24 indicated positive findings for amphetamines, marijuana, cocaine, fentanyl and opiates.
-There were no counseling sessions to address the positive UDS from 7/15/24 and 8/15/24.

Review on 9/17/24 of client #3's record revealed:
-Admission date of 1/2/24.
-Diagnosis of Opioid Use Disorder- Severe.
-In the last 6 months, there were no counseling sessions for the months of March, April, May, June, July and August.
-Client #3 did not receive two counseling sessions per month.
-UDS conducted on 6/10/24 indicated positive findings for cocaine and fentanyl.

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V 238	Continued From page 21 -UDS conducted on 7/5/24 indicated positive findings for opiates and fentanyl. -UDS conducted on 8/6/24 indicated positive finding for fentanyl. -There were no counseling sessions to address the positive UDS from 6/10/24, 7/5/24 and 8/6/24. Review on 9/17/24 of client #4's record revealed: -Admission date of 6/6/17. -Diagnosis of Opioid Use Disorder- Severe on Maintenance Therapy. -In the last 6 months, there were no counseling sessions for the months of March, April, June, July and August. -UDS conducted on 7/19/24 indicated positive findings for amphetamines and marijuana. -UDS conducted on 8/2/24 indicated positive findings for amphetamines and marijuana. -UDS conducted on 9/13/24 indicated positive findings for amphetamines and marijuana. -There were no counseling sessions to address the positive UDS from 7/19/24, 8/2/24 and 9/13/24. Review on 9/18/24 of client #5's record revealed: -Admission date of 9/19/18. -Diagnosis of Opioid Use Disorder- Severe. -In the last 6 months, there were no counseling sessions for the months of March, May, June, July and August. -There was no counseling session completed since 4/2/24. Review on 9/18/24 of client #7's record revealed: -Admission date of 7/12/23. -Diagnosis of Opioid Use Disorder- Severe on Maintenance Therapy. -In the last 6 months, there were no counseling sessions for the months of March, May, June, July and August.	V 238		

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V 238	Continued From page 22 -UDS conducted on 6/5/24 indicated positive findings for opiates. -There was no counseling session to address the positive UDS from 6/5/24. Review on 9/18/24 of client #8's record revealed: -Admission date of 8/20/19. -Diagnosis of Opioid Use Disorder- Severe. -In the last 6 months, there were no counseling sessions for the months of March, April, May, June and August. -UDS conducted on 7/17/24 indicated positive findings for benzodiazepines and marijuana. -UDS conducted on 8/15/24 indicated positive finding for benzodiazepines. -There were no counseling sessions to address the positive UDS from 8/15/24. Review on 9/17/24 of client #9's record revealed: -Admission date of 8/22/18. -Diagnosis of Opioid Use Disorder- Severe, On Maintenance Therapy. -In the last 6 months, there were no counseling sessions for the months of April, June and August. -There was no counseling session completed since 7/15/24. Review on 9/17/24 of client #10's record revealed: -Admission date of 3/14/23. -Diagnosis of Opioid Use Disorder- Severe, On Maintenance Therapy. -In the last 6 months, there were no counseling sessions for the months of May, June and August. -UDS conducted on 7/9/24 indicated positive findings for cocaine, opiates, marijuana and fentanyl. -UDS conducted on 8/26/24 indicated positive	V 238		

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findings for cocaine, fentanyl and opiates.
-UDS conducted on 9/3/24 indicated positive findings for cocaine, fentanyl and opiates.
-There were no counseling sessions to address the positive UDS from 7/9/24, 8/26/24 and 9/3/24.

Review on 9/18/24 of client #12's record revealed:
-Admission date of 7/21/20.
-Diagnosis of Opioid Use Disorder- Severe.
-In the last 6 months, there were no counseling sessions for the months of July and August.
-There was no counseling session completed since 6/3/24.
-UDS conducted on 6/6/24 indicated positive findings for marijuana, cocaine and fentanyl.
-UDS conducted on 7/10/24 indicated positive findings for cocaine and fentanyl.
-UDS conducted on 8/15/24 indicated positive findings for cocaine, fentanyl and opiates.
-UDS conducted on 9/4/24 indicated positive findings for cocaine, fentanyl and opiates.
-There were no counseling sessions to address the positive UDS from 6/6/24, 7/10/24, 8/15/24 and 9/4/24.

Review on 9/18/24 of client #13's record revealed:
-Admission date of 5/16/22.
-Diagnosis of Opioid Use Disorder- Severe.
-No UDS were conducted in the months of June and July of 2024.
-There was no counseling session completed since 4/26/24.

Review on 9/18/24 of client #14's record revealed:
-Admission date of 8/29/17.
-Diagnosis of Opioid Use Disorder- Severe.
-In the last 6 months, there were no counseling

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V 238	Continued From page 24 sessions for the months of June and July. Review on 9/18/24 of client #15's record revealed: -Admission date of 2/22/12. -Diagnosis of Opioid Use Disorder- Severe. -There was no counseling session completed since 4/24/24. Interview on 9/19/24 with client #17 revealed: -She had a new counselor. -She met 1 hour monthly with her counselor, but she tried to see the counselor once every 2 weeks. Interview on 9/19/24 with client #18 revealed: -She had been receiving treatment at this facility for the past 20 years. -She had a new counselor that she met with monthly. Interview on 9/19/24 with client #19 revealed: -He currently was not assigned a counselor. -Had been receiving treatment at facility for the past 2.5 years. -If he needed to see a counselor, the Director or one of the counselors were available. Interview on 9/19/24 with the Director revealed: -The facility was currently understaffed. -"Having only two counselors and myself, have made it difficult to ensure clients are seen by counselors." - She confirmed the facility failed to ensure counseling sessions were completed after a positive Urine Drug Screen (UDS) for clients #2, #3, #4, #7, #8, #10 and #12. This deficiency constitutes a re-cited deficiency.	V 238		

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V 238	Continued From page 25 This deficiency is cross referenced into 10A NCAC 27G .3601 Outpatient Opioid Treatment - Scope (Tag 233) for a Type B rule violation and must be corrected within 45 days.	V 238		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to	V 536		

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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 26 Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing 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:	V 536		

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	MHL032-412	A. BUILDING: _____ B. WING _____	R 09/20/2024

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V 536	Continued From page 27 (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.	V 536		

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V 536	Continued From page 28 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention for 5 of 5 audited staff (Staff #1, Staff #2, the Director, the Nurse and the Lead Nurse). The findings are: Review on 9/18/24 of Staff #1's personnel record revealed: -She was hired on 7/18/24. -She was hired as a Counselor. -Relias online training: -7/17/24 North Carolina Rules for Prevention	V 536		

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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 2/5/24.
-She was hired as a Counselor.
-Relias online training:
-2/27/24- North Carolina Rules for Prevention 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 the Nurse's personnel record revealed:
-She was hired on 9/8/13.
-She was hired as a Dispensing Nurse.
-Relias online training:
-6/28/24- North Carolina Rules for Prevention 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

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V 536	Continued From page 30 competencies. Review on 9/18/24 of the Lead Nurse's personnel record revealed: -She was hired on 7/1/24. -She was hired as the Lead Nurse. -Relias online training: -7/10/24- North Carolina Rules for Prevention 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 the Director's personnel record revealed: -She was hired on 12/4/23. -She was hired as the Regional Director Operations. -Relias online training: -12/26/24- North Carolina Rules for Prevention 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. Interview on 9/20/24 with the Director revealed: -Training was completed online only. -Training was not a live session. -There was not an instructor available for questions while completing the course.	V 536		

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V 536	Continued From page 31 -There was not an instructor signing the certificate once the course was completed to verify staff's competencies. Interview on 9/19/24 with the Regional Director revealed: -She had been informed by her Human Resources director that the state had approved the curriculum they were using. -She would review approved curriculums in the state of North Carolina and register staff from the center for the training.	V 536		