Pennsylvania Department of Health
Inspection Results

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COATESVILLE TREATMENT CENTER

1825 EAST LINCOLN HIGHWAY
COATESVILLE, PA 19320

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/12/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection, conducted on March 11 - 12, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Coatesville Treatment Center was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection.

Plan of Correction

704.2(b) LICENSURE Staffing Plan

704.2. Compliance plan. (b) The plan documenting the qualifications and training of staff shall be presented to Department licensing representatives at the time of the project's site visit.

Observations

Based on a review of the Staffing Requirements Facility Summary Report form, the facility failed to document complete and accurate information on the staffing form.

The findings include:

The Staffing Requirements Facility Summary Report form was completed by the facility on February 24, 2015. The facility failed to document all of the educational components and the current training plans.

Page 2 - The facility failed to document all of the required components under the education column to include institution, degree, major, and date of issue for seven out of seven clinical staff.

Page 4 & 7 - The facility failed to document current individual training plans for seven out of seven clinical staff, and for all support staff on page seven.

The facility was given until the completion of the inspection to update the information.

Plan of Correction

Clinic Director will ensure that the Staffing Form is completed with accruacy during the presummition process. If any corrections are needed, Clinic Director will submit all manual corrections during the presummition process.

The findings were reviewed with facility staff during the licensing process.

704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Observations

Based on a review of the Staffing Requirements Facility Summary Report form, the facility failed to ensure all staff persons receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of TB/STD training.

The findings include:

The Staffing Requirements Facility Summary Report form was completed by the facility on February 24, 2015. The facility failed to ensure all staff persons received a minimum of 6 hours of HIV/AIDS and at least 4 hours of TB/STD training. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Employee # 4 is a front office assistant that was hired February 22, 2001. HIV/AIDS training and TB/STD training was to be completed within the first 2 years of employment or by February 22, 2003. The facility failed to ensure employee # 4 completed the required training's at the time of inspection on March 12, 2015.

The findings were reviewed with facility staff during the licensing process.

Plan of Correction

Employee #4 was actually hired on February 22, 2011 as a part-time front office assistant. She completed internal trainings offered by CRC Health Group. As there are limited trainings in the local vicinity, this employee will be registered for HIV/AIDS and TB/STD as registration on the DDAP website becomes available within a 30 miles radius. Clinic Director will ensure that they are registered by 7/31/2015. Front office staff requested registration for trainings in May, but have not received a confirmation. Clinic Director has also sent a follow-up. Clinic Director will which out to SCA authority by 4/16/2015 if no confirmation of regaistration is received.

Going forward Clinic Director will ensure that all administrative staff including Front Office Staff will receive HIV & TB/STD training within the first year of being hire.

705.28 (c) (4) LICENSURE Fire safety.

705.28. Fire safety. (c) Fire extinguishers. The nonresidential facility shall: (4) Instruct staff in the use of the fire extinguisher upon staff employment. This instruction shall be documented by the facility.

Observations

Based on a review of personnel records, the facility failed to provide documentation of fire extinguisher training upon staff employment.

The findings include:

Three personnel records were reviewed on March 12, 2015 to verify that staff had been instructed in the use of a fire extinguisher upon employment. The facility failed to document the completion of fire extinguisher training upon staff employment in personnel record, # 2 and 3.

Plan of Correction

Employee #2 and Employee #3 received Healthy & Safety training at hire. All detail regarding Health & Safety trainings will be maintained in a the Health & Safety binder. The Certificates used for proof of completeion has been updated to include the title of the training and the date completed. The certificate will be attached to the detailed training completion report that includes the fire extinguisher training. The detail regarding the training will also be maintained in the personnel files. Clinic Director will submit detail regarding the Health & Safety trainings along with a copy of the certificates during the presummition. Health & Safety Officer will provide Health & Safety training to all new hires upon hire.

Employee # 2 was hired April 7, 2014. Fire extinguisher training was due upon hire; however the facility failed to provide documentation of this training at the time of the inspection on March 12, 2015.

Employee # 3 was hired March 31, 2014. Fire extinguisher training was due upon hire; however the facility failed to provide documentation of this training at the time of the inspection on March 12, 2015.

The findings were reviewed with facility staff during the licensing process.

705.28 (d) (1) LICENSURE Fire safety.

705.28. Fire safety. (d) Fire drills. The nonresidential facility shall: (1) Conduct unannounced fire drills at least once a month.

Observations

Based on a review of the facility's fire drill log, the facility failed to conduct unannounced fire drills at least once a month and the fire drill logs were missing required components.

The findings include:

The facility's fire drill log was reviewed on March 12, 2015, covering the period of May 2014 through February 2015. The facility failed to conduct an unannounced fire drill during the months of July 2014, August 2014, and October 2014.

In addition, the facility is to maintain a written fire drill record that includes the date, time, the amount of time it took for evacuation, the exit route used, the number of persons in the facility at the time of the drill, problems encountered and whether the fire alarm or smoke detector was operative.

The facility failed to include on their fire drill logs the amount of time it took for evacuation, the exit route used, and whether the fire alarm or smoke detector was operative.

The findings were reviewed with facility staff during the licensing process

Plan of Correction

Clinical Supervisor created a yearly calendar for the Health and Safety Officer to utilize to track all monthly random drills and to ensure they are completed each month. Clinical Supervisor will review the calendar each month to ensure they are completed. The process was reviewed with the Health and Safety Officer on 3/16/2015. Additionally, the Health & Safety Officer will ensure to include on the fire drill logs the amount of time it took for evacuation, the exit route used, and whether the fire alarm or smoke detector was operative.

Health & Saftey Officer will complete all require drills each month and document the results. All documentation relating to Healthy & Safety drills will continue to be maintained in the Health & Safety Binder. Clinical Supervisor will also review the fire drill log each month to ensure all documentation has been captured.

705.28 (d) (3) LICENSURE Fire safety.

705.28. Fire safety. (d) Fire drills. The nonresidential facility shall: (3) Ensure that all personnel on all shifts are trained to perform assigned tasks during emergencies.

Observations

Plan of Correction

Based on a review of personnel records, the facility failed to provide documentation that all personnel are trained to perform assigned tasks during emergencies.

The findings include:

Three personnel records were reviewed on March 12, 2015, to verify that staff had been

trained to perform assigned tasks during emergencies. The facility failed to document the completion of emergency training in personnel record, # 2 and 3.

Employee # 2 was hired April 7, 2014. Emergency training was due upon hire; however the facility failed to provide documentation of this training at the time of the inspection on March 12, 2015.

Employee # 3 was hired March 31, 2014. Emergency training was due upon hire; however the facility failed to provide documentation of this training at the time of the inspection on March 12, 2015.

The findings were reviewed with facility staff during the licensing process.

Employee #2 and Employee #3 received Healthy & Safety training at hire. All detail regarding Health & Safety trainings will be maintained in a the Health & Safety binder. The Certificates used for proof of completeion has been updated to include the title of the training and the date completed. The certificate will be attached to the detailed training completion report that includes the fire extinguisher training. The detail regarding the training will also be maintained in the personnel files. Clinic Director will submit detail regarding the Health & Safety trainings along with a copy of the certificates during the presummition. Health & Safety Officer will provide Health & Safety training to all new hires upon hire.

709.22(e) LICENSURE Governing Body

709.22. Governing body. (e) If a facility is publicly funded, the governing body shall make available to the public an annual report which includes, but is not limited to:

Observations

Based on a review of administrative documentation, the governing body failed to make an annual report available to the public.

The findings include:

The facility's administrative documentation was reviewed on March 12, 2015.

The governing body failed to provide the annual report for the 2013/2014 fiscal year during the pre-submission process which was due February 20, 2014 or during the annual inspection which was conducted March 11 - 12, 2015.

The findings were reviewed with facility staff during the licensing process.

Plan of Correction

Clinic Director will submitted the Annual Report that is completed internal by Clinicl Director during the pre-submission as well as the latest version of the Governing Body. Morning Star is the organization that produces the Governing Body reports typically by the end of the first Quarter. The Annual Report that is created by Clinic Director includes strategic planning goals.

The facility specific Annual Report that includes such items as strategic planning, orgainization chart, and items accomplished over the year will be completed by February 15th by Clinic Director. This report will be sent during the presummition process along with the proof of publication. The Annual Report provided and created by the Governing Body for Acadia Healthcare will be completed by the end of Quarter 1 depending on the fiscal closing.

709.28(b) LICENSURE Confidentiality

709.28. Confidentiality. (b) The project shall secure client records within locked storage containers.

Observations

Based on a physical plant inspection, the facility failed to secure client records within locked storage containers.

The findings include:

A physical plant inspection was conducted on March 12, 2015. The facility failed to secure client records within locked file cabinets in building A and B.

Building A - The facility failed to maintain client records within locked file cabinets as client records are stored on open shelves.

Building B - The facility failed to maintain client records within locked file cabinets as client records are stored on open shelves. This is a multi-purpose room which contains a fax machine and is accessible by all staff. In addition, during the physical plant inspection a stack of loose client documents, filing or a client record, was observed not in a folder or file, and was placed on a shelf by the door.

The findings were reviewed with facility staff during the licensing process.

Plan of Correction

Based on 42 CFR regulation charts must be in a locked container which our chart room is considered a locked container. Both chart rooms were approved previously by state surveyors as both rooms were equipped with a locked key pad with a code that only staff have access to. Both rooms are locked at all times.

Photos were taken of both chart rooms and submitted to the surveyor and supervisor to review. Chart Room A was approved. Chart Room B was not approved. Locked file cabinets will be added to Chart Room B.

709.28(c) LICENSURE Confidentiality

709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent shall be in writing and include, but not be limited to:

Observations

Based on a review of client records, the facility failed to comply with the limitations imposed by 4 Pa. Code 255.5 for an informed and voluntary consent for the disclosure of information in three of twelve client records reviewed.

The findings include:

4 Pa. Code 255.5 states:

Information released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials, pursuant to paragraphs (1), (2), (4),(7), (8) or subsection (a) of this section, is for the purpose of determining the advisability of continuing the client with the assigned project and shall be restricted to the following.

Plan of Correction

All information requested by patients to be submitted to Rover Transportation is reviewed by the patient. The patient has the right to limit any information including medication. Rover is a transportation services that is provided through local government funding (Chester County Department of Public Welfare) as apart of the benefits.

Consents to release information to Rover Transporation are only completed as needed depending on county of residence and their financial payment status. Information was requested by Rover in order to release clients travel reimbursement checks. Proof of attenednce was needed to release the check and per the clients request, their dispensing history was released in order for them to be reibursed travel for those days.

Clinical Supervisors will conduct a training with staff on 4/6/2015 to review consent to release information to ensure all appropriate releases are utilized and all dates are entered and all check boxes are marked. All consent of releases will be completed as needed to release only the information

(1) Whether the client is or is not in treatment.

(2) Client's prognosis.

(3) The nature of the project.

(4) A brief description of the client's progress.

(5) A short statement as to whether the client has relapsed

Twelve client records requiring documentation of informed and voluntary consents were reviewed on March 12, 2015. The facility failed to obtain an informed and voluntary consent to release in client records, # 3, 15 and 16.

Client # 3 was admitted to the program on November 21, 2014. Six consent to release forms were reviewed in client #3's record and the facility failed to document that client # 3 was offered a copy of those consent to release forms. In addition, one consent to release did not include the a dated witness signature.

Client # 15 was admitted to the program on January 29, 2015. The facility documented the release of information to include client # 5's medication records to a governmental agency; this information exceeds the limitations imposed at 4 Pa. Code 255.5.

On 1/29/15 the facility documented the release of 'dates of attendance' on consent to release to a governmental agency. The licensing specialist inquired about this release and was informed that the patient ' s methadone dosing log sheet or medication record was released as a means to verify dates for transportation payment. In addition, the facility failed to offer seven consents to client # 15.

Client # 16 was admitted to the program on November 5, 2014. The facility documented the release of 'All records' to a governmental agency on 11/7/14. This release constitutes a general consent and does not comply with 4 Pa. Code 255.5. In addition, the facility failed to offer two consents to client # 16.

The findings were reviewed with facility staff during the licensing process.

covered on the release. Clinical Supervisors will provided monthly random chart audits to insure all consent of release are updated as needed and filled out correctly.

709.33(a) LICENSURE Notification of Termination

709.33. Notification of termination. (a) Project staff shall notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project. The notice shall include the reason for termination.

Observations

Based on a review of client records, the facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project in two discharge records.

Plan of Correction

All involuntary tapers are provided with a termination letter. All tapers related to medical necessity will continue to be documented by the Medical Director and maintained in the medical section of the chart. Medical Director will continue to document interventions used prior to the medical taper

The findings include:

Two administratively discharged client records were reviewed on March 9, 2015. The facility failed to notified the client, in writing, of a decision to involuntarily terminate the client's treatment at the project in client records, #13 and 14.

Client # 13 was admitted to the program on October 7, 2014 and administratively discharged on March 2, 2015. The facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project as of the date of the licensing inspection.

Client # 14 was admitted to the program on February 27, 2014 and administrate discharged on January 5, 2015. The facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project as of the date of the licensing inspection.

The findings were reviewed with facility staff during the licensing process.

including the recommendation to a higher level of care. If the patient refuses a higher level of care, Medical Director will move forward with the medical taper. Going forward, patient will receive a letter of termination that will include the Medical Directors recommendation based off of an endangerment to their health (Based on illicit use and other contraindication with Medication Assisted Treatment). Clinic Director will maintain a copy of the documentation relating to involuntary tapers in the incident report binder.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Based on a review of patient records, the facility failed to complete a random urinalysis at least monthly that included a test for opiates, methadone, amphetamines, barbiturates, cocaine and benzodiazepines in two of ten patient records reviewed.

The findings include:

Ten patient records were reviewed on March 9, 2015. The facility failed to show documentation of a random urinalysis that included a test for opiates, methadone, amphetamines, barbiturates, cocaine and benzodiazepines in patient records, #1 and 5.

Patient # 1 was admitted to the program on October 8, 2014. The facility failed to complete a monthly drug-screening urinalysis for the month of December 2014.

Patient # 5 was admitted to the program on January 25, 2001. The facility failed to complete a monthly drug-screening urinalysis for the months of November 2014 and February 2015.

Plan of Correction

Director of Nursing will run a report out of the dispensing system on the 15th of each month to ensure all patients have been given a UDS including auto fails. Clinical Supervisors will conduct training on 4/13/2015 with Clinical Staff regarding the importance of timely filing and the accountability factor for not having this done. Clinical Supervisors will also ensure that 4 Peer Reviews our conducted each year to cover each quarter and to ensure all documentation is included in the patient chart.

The findings were reviewed with facility staff during the monitoring inspection.

715.19(1) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (1) A narcotic treatment program shall provide each patient an average of 2.5 hours of psychotherapy per month during the patient 's first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations

Based on a review of patient records, the facility failed to provide each patient an average of 2.5 hours of psychotherapy per month during the patient's first 2 years in five of eight patient records reviewed.

Plan of Correction

Clinical Supervisors added counseling hours to the peer review tracking sheet to highlight the number of counseling hours completed. Clinical Supervisors will address all lack of counseling hours with Counselor and patient. Clinical Supervisors will run on the 15th and 25th of every month a counseling hours status report to ensure the hours are met.

The findings include:

Eight patient records were reviewed on March 9, 2015. The facility failed provided 2.5 hours of psychotherapy per month during the patient's first 2 years in treatment in patient records, #3, 6, 7, 8 and 9.

Patient #3 was admitted to the program on November 21, 2014. The facility failed to document 2.5 hours of psychotherapy per month for the following months; December 2014, January 2015 and February 2015.

December 2014 - no psychotherapy provided.

January 2015 - 1 hour of psychotherapy provided.

February 2015 - 2 hours of psychotherapy provided

Patient # 6 was admitted to the program on December 1, 2014. The facility failed to document 2.5 hours of psychotherapy per month for the following months; January 2015 and February 2015.

January 2015 - 1 hour of psychotherapy provided.

February 2015 - no psychotherapy provided.

Patient # 7 was admitted to the program on November 10, 2014. The facility failed to document 2.5 hours of psychotherapy per month for the following months; December 2014, February 2015.

Patient # 8 was admitted to the program on November 20, 2014. The facility failed to document 2.5 hours of psychotherapy per month for the following months; January 2015 and February 2015.

Patient # 9 was admitted to the program on December 17, 2013. The facility failed to document 2.5 hours of psychotherapy per month for the following months; December 2014, January 2015 and February 2015.

December 2014 - no psychotherapy provided.

January 2015 - 1 hour of psychotherapy provided.

February 2015 - 1 hour of psychotherapy provided

The findings were reviewed with facility staff during the monitoring inspection.

715.22(a) LICENSURE Patient grievance procedures

(a) A narcotic treatment program shall develop and utilize a patient grievance procedure.

Observations

Based on a review of patient records, the facility failed to utilize a patient grievance procedure in two of two patient records.

The findings include:

Two administratively discharged patient records were reviewed on March 9, 2015. The facility failed to permit patient # 13 and 14 a full and fair opportunity to grieve an involuntarily termination.

Patient # 13 was admitted to the program on October 7, 2014 and administratively discharged on March 2, 2015. The facility failed to permit patient # 13 a full and fair opportunity to be heard, to question and confront persons and evidence used against them and to have a fair review of a grievance by the narcotic treatment program director. If the grievance is filed against the narcotic treatment program director, the review of the case shall be conducted by either a multi-representative group of the narcotic treatment program or a subcommittee of the governing body instituted for the express purposed of grievance adjudication.

Patient # 14 was admitted to the program on February 27, 2014 and administrate discharged on January 5, 2015. The facility failed to permit patient # 14 a full and fair opportunity to be heard, to question and confront persons

Plan of Correction

All involuntary tapers are provided with a termination letter. All tapers related to medical necessity will continue to be documented by the Medical Director and maintained in the medical section of the chart. Medical Director will continue to document interventions used prior to the medical taper including the recommendation to a higher level of care. If the patient refuses a higher level of care, Medical Director will move forward with the medical taper. Going forward, patient will receive a letter of termination that will include the Medical Directors recommendation based off of an endangerment to their health (Based on illicit use and other contraindication with Medication Assisted Treatment). The letter will include the patient's right to grieve the termination. Clinic Director will maintain a copy of the documentation relating to involuntary tapers in the incident report binder.

and evidence used against them and to have a fair review of a grievance by the narcotic treatment program director. If the grievance is filed against the narcotic treatment program director, the review of the case shall be conducted by either a multi-representative group of the narcotic treatment program or a subcommittee of the governing body instituted for the express purposed of grievance adjudication.

The findings were reviewed with facility staff during the licensing process.

715.23(c)(1-7) LICENSURE Patient records

(c) An annual evaluation of each patient 's status shall be completed by the patient 's counselor and shall be reviewed, dated and signed by the medical director. The annual evaluation period shall start on the date of the patient 's admission to a narcotic treatment program and shall address the following areas: (1) Employment, education and training. (2) Legal standing. (3) Substance abuse. (4) Financial management abilities. (5) Physical and emotional health. (6) Fulfillment of treatment objectives. (7) Family and community supports.

Observations

Based on a review of patient records, the facility failed to document an annual evaluation in one of two patient records reviewed.

The findings include:

Two patient records were reviewed on March 9, 2015, for documentation of an annual evaluation. The facility failed to document an annual evaluation in patient record, # 5.

Patient # 5 was admitted to the program on January 25, 2001. The facility failed to document an annual evaluation in patient record # 5 which was to start on the date of the patient's admission to the narcotic treatment program or by January 25, 2015.

The findings were reviewed with facility staff during the monitoring inspection.

Plan of Correction

Clinical Supervisor will perform monthly chart audits to ensure all clinical and medical documentation including annual evaluations are displayed in the patient chart. Peer Reviews will also be conducted once a quarter to review all documentation in the charts. Ntifications of Corrections will be given for any missing data.

All patients upon admission will continue to be given a Physical that will be maintained in the chart. Director of nursing and Physician Assistant will continue to track all annual evaluations to ensure they are completed within the approapraite time frame, which would be prior to their anniversary/admission date.

709.91(b)(6) LICENSURE Intake and admission

709.91. Intake and admission. (b) Intake procedures shall include documentation of: (6) Psychosocial evaluation.

Observations

Based on a review of client records, the facility failed to document a psychosocial evaluation in two of two drug-free client records reviewed.

The findings include:

Plan of Correction

Clinical Supervisors will implement a tracking system after patients are assigned a counselor within 2 weeks after admission to ensure that psychosocials are completed within 30 days of admission. The tracking system will be reviewed with Counselors on 4/13/2015. The Clinical SUpervisor will review the tracking sheet weekly. If psychosocials are not completed within the appropriate timeframe, Clinical Supervisor will ensure the patient is scheduled for the psychosocial review to be completed within a week of the initial finding.

Two drug-free client records were reviewed on March 9, 2015, for documentation of a psychosocial evaluation. The facility failed to document a psychosocial evaluation in client records, # 15 and 16.

Client # 15 was admitted to the program on January 29, 2015. The facility failed to document a psychosocial evaluation in client record # 15 as of the date of the licensing inspection.

Client # 16 was admitted to the program on November 5, 2014. The facility failed to sign, date and complete an evaluative psychosocial evaluation in client record # 16 as of the date of the licensing inspection.

The findings were reviewed with facility staff during the licensing process.

709.92(a) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (a) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:

Observations

Based on a review of client records, the facility failed to document an individual treatment and rehabilitation plan which was developed with a client and included support services in four of ten records reviewed.

The findings include:

Ten client records requiring documentation of an individual treatment and rehabilitation plan were reviewed on March 12, 2015. The facility failed to document an individual treatment and rehabilitation plan which was developed with a client and included support services in client records, # 2, 3, 6 and 7.

Client # 2 was admitted to the program on February 4, 2015. The facility documented an individual treatment plan on March 2, 2015; however, the plan was not developed with or signed by client # 2.

Client # 3 was admitted to the program on November 21, 2014. The facility documented the individual treatment plan on February 19, 2015; however, the plan did not contain documentation of proposed support services being offered.

Client # 6 was admitted to the program on December 1, 2014. The facility failed to document an individual treatment

Plan of Correction

Clinical Supervisors will review all preliminary treatment plans to ensure all support services are highlighted. Clinical Supervisors have reviewed the treatment plans of client #6 and provide the counselor with the correction to make.

Clinical Supervisor will conduct random chart reviews each month on all direct reports to review clinical documentation starting 04/6/2015. Peer Reviews will be conducted quarterly. The last Peer Review will be completed by 4/3/2015. All plans of correction from the Peer Review Results are due by 4/10/2015.

plan with client # 6 at the time of the licensing inspection on March 12, 2015.

Client # 7 was admitted to the program on November 10, 2014. The facility documented the individual treatment plan on November 19, 2014; however, the plan did not contain documentation of proposed support services being offered.

The findings were reviewed with facility staff during the licensing process.

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Based on a review of client records, the facility failed to document treatment and rehabilitation plan updates at least every 60 days in four of ten records reviewed.

The findings include:

Ten client records requiring documentation of treatment plan updates at least every 60 days were reviewed on March 12, 2015. The facility failed to document treatment plan updates every 60 days in client records, # 7, 9, 12 and 16.

Client # 7 was admitted to the program November 10, 2014. The facility documented the individual treatment plan on November 19, 2014. The facility failed to document a treatment plan update at least every 60 days. There was no documentation of an update as of the date of the licensing inspection.

Client # 9 was admitted to the program on December 17, 2013. The last two treatment plan updates were documented, October 29, 2014 and January 7, 2015. The facility failed to document treatment plan update for March 7, 2015.

Client # 12 was admitted to the program on March 29, 2007 and discharged on January 12, 2015. The last treatment plan update documented in client #12's record was dated July 23, 2014. The facility failed to document treatment plan updates for the following months; September 2014 and November 2014.

Client # 16 was admitted to the program on November 5, 2014. The last two treatment plan updates were documented, November 5, 2014 and February 23, 2015. The facility failed to document treatment plan updates at least

Plan of Correction

Clinical Supervisors will conduct random chart reviews each month on all direct reports to review clinical documentation starting 04/6/2015. Peer Reviews will be conducted quarterly. The last Peer Review will be completed by 4/3/2015. All plans of correction from the Peer Review Results are due by 4/10/2015. The carts of client records #7,9,12, and 16 have been reviewed and correction have been made.

every 60 days.

The findings were reviewed with facility staff during the inspection process.

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COATESVILLE TREATMENT CENTER

1825 EAST LINCOLN HIGHWAY
COATESVILLE, PA 19320

Survey conducted on 09/16/2015

INITIAL COMMENTS

This report is a result of an on-site follow-up investigation that was conducted on September 16, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, Coatesville Treatment Center was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

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COATESVILLE TREATMENT CENTER

1825 EAST LINCOLN HIGHWAY
COATESVILLE, PA 19320

Survey conducted on 02/18/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on February 17-18, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Coatesville Treatment Center, was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.6(a) LICENSURE Clinical Supervisor Qualifications

704.6. Qualifications for the position of clinical supervisor. (a) A drug and alcohol treatment project shall have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

Observations

Based on the administrative review of the staffing requirements facility summary report, the facility failed to have one clinical supervisor for every eight full-time equivalent (FTE)counselors or counselor assistants, or both.

The findings include:

The staffing requirements facility summary report was reviewed on February 17-18, 2016. A final review took place on February 22, 2016. The facility failed to employ a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both. There are currently 13 full and part time counselors employed.

Employee #3 is a clinical supervisor with a current caseload of 6 patients. Because employee is serving in the capacity of a clinician employee #3 will not be considered a full-time clinical supervisor.

Employee #7 is a clinical supervisor with a current caseload of 6 patients. Because employee is serving in the capacity of a clinician employee #7 will not be considered a full-time clinical supervisor.

Plan of Correction

The Clinical Supervisors (Employee 3 and 7) caseloads will be reduced to five patients and placed on the caseload of other Counselors that have the capacity to increase their caseload based on the new regulation. The patients that will be removed from both caseloads have been in treatment for over 3 years and are in a higher phase of recovery. These patients are only required to meet for individual Counseling 6x per year based on the regulation. Clinical Supervisor will reduce the caseload to five patients each in the system on 3/26/2016.

If our census continues to increase, Clinic Director will follow the new hiring process and submit for approval to the Regional Director to hire another Counselor and reduce the number of patients being carried by the Clinical Supervisors and Counselors as needed. Once approved, The Recruiting team will advertise for the position. Clinical Supervisors will continue to be responsible for monitoring caseloads to ensure it meets the new regulation requirement. Clinical Supervisor will continue to assign patients to caseloads.

These findings were reviewed with facility staff after the licensing process.

704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Observations

Based on a review of personnel and training records, the facility failed to provide documentation of HIV/AIDS and TB/STD training in one of eleven applicable records reviewed

The findings include:

Eleven personnel records which required documentation of mandatory communicable disease training were reviewed on February 17-18, 2016. The facility failed to provide documentation of HIV/AIDS and TB/STD training for employee #11.

Employee #11 was hired on February 22, 2011 as a part-time Front Office Assistant. This employee was required to obtain six hours of HIV/AIDS and 4 hours of TB/STD training by February 22, 2013. Employee #11 failed to obtain the training as of the date of the inspection.

These findings were reviewed with facility staff during the licensing process.

This is a repeat citation.

The facility was previously cited for noncompliance of this standard during the March 11-12, 2015 licensing inspection. The facility's plan of correction approved on April 22, 2015 stated that the Clinic Director would ensure that this employee would be registered for training by 7/31/2015.

Plan of Correction

Employee #11 will be registered to attend the HIV/AIDS Training in Bucks County on April 29th. Employee #11 will be registered for TB/STD Training in Philadelphia on Friday, May 20th.

Clinic Director, going forward, will ensure that all employees, part-time and full-time will be scheduled for HIV/AIDS and TB/STD within the first year of employment. Clinic Director will locate HIV/AIDS training through the approved training list provided by the County and State. Clinic Director will ensure that all new staff are register for the training as apart of their oerientation process. Direct supervisors will be responsible for tracking the trainings for their direct reports on a monthly basis to ensure all required trainings are meet by end of their first year of employment.

704.11(f)(2) LICENSURE Trng Hours Req-Coun

704.11. Staff development program. (f) Training requirements for counselors. (2) Each counselor shall complete at least 25 clock hours of training annually in areas such as: (i) Client recordkeeping. (ii) Confidentiality. (iii) Pharmacology. (iv) Treatment planning. (v) Counseling techniques. (vi) Drug and alcohol assessment. (vii) Codependency. (viii) Adult Children of Alcoholics (ACOA) issues. (ix) Disease of addiction. (x) Aftercare planning. (xi) Principles of Alcoholics Anonymous and Narcotics Anonymous. (xii) Ethics. (xiii) Substance abuse trends. (xiv) Interaction of addiction and mental illness. (xv) Cultural awareness. (xvi) Sexual harassment. (xvii) Developmental psychology. (xviii) Relapse prevention. (3) If a counselor has been designated as lead counselor supervising other counselors, the training shall include courses appropriate to the functions of this position and a Department approved core curriculum or comparable training in supervision.

Observations

Based on a review of personnel records, the facility failed to document the completion of 25 clock hours of annual training

Plan of Correction

Employee #8 completed 21 hours based on a miscalculation of her hours. Going forward to ensure all 25 hours are

required for counselors in one of eleven personnel records reviewed.

The findings included:

Eleven personnel records were reviewed on February 17-18, 2016. Six counselor records were reviewed for 25 clock hours of annual training. The facility failed to document 25 clock hours of annual training in one of six counselor personnel records.

Employee # 8 was hired on March 31, 2014. The facility training year is from January through December. The training year for January to December 2015 was reviewed. Employee # 8 only completed 22.0 clock hours of annual training for 2015.

These findings were reviewed with facility staff during the licensing process.

completed on time by all members of the Clinical Staff, Clinical Supervisors will do a month audit to track all training hours for their direct reports. There will be an additional audit on 12/15 to ensure all hours have been met. If the hours have not been met, staff will be required to complete online approved trainings by DDAP including those offered by the PCB Board (Pennsylvania Certification Board).

715.9(b)(2) LICENSURE Intake

(b) Exceptions to the requirements in subsection (a) are: (2) Upon readmitting a patient who has been out of a narcotic treatment program for 6 months or less after a voluntary termination, the narcotic treatment program shall update the information in and review the patient 's file to show current opiate narcotic dependency, but need not conduct a physical examination and applicable laboratory tests. Privileges earned during the previous treatment may be reinstated at the discretion of the narcotic treatment physician.

Observations

Based on a review of patient records, the facility failed to verify the individual's identity, including name, address, and date of birth, and other identifying data in one of six records reviewed.

The findings include:

Six narcotic treatment patient records were reviewed on February 17-18, 2016, to ensure the facility screened individuals prior to administration of an agent. The facility failed to verify the individual's identity, including name, address, date of birth, and other identifying data prior to administration of an agent in record #5.

Patient #5 was admitted to the program on July 4, 2008 and was an active patient at the time of the inspection. The facility failed to provide documentation that patient #5 had been screened prior to administration of an agent.

The findings were reviewed with facility staff during the monitoring inspection.

Plan of Correction

Due to some technical issues with our patient system, some patient pictures were deleted. The Front Office has went through each patient in the Tower system and documented which photos were missing. New photos were taken and uploaded to the system. Each six months, the Front Office staff will be responsible for taking new photos and uploading them to the system as well as taking a copy of the picture ID and place them in the patient file.

This is a repeat citation.

The facility was previously cited for noncompliance of this standard during the March 17-18, 2015 licensing inspection. The facility's plan of correction was submitted on April 13, 2015 and approved on April 30, 2015

715.13(b) LICENSURE Patient identification

(b) A narcotic treatment program shall maintain onsite a photograph of each patient which includes the patient 's name and birth date. The narcotic treatment program shall update the photograph every 3 years.

Observations

Based on the review of patient records and discussion with staff, the facility failed to demonstrate that patient photographs are updated every three years.

The findings include:

Dosing was observed on February 18, 2016 at approximately 9:00 am. The dosing system, Tower, includes a photograph of each active patient. There was no date of when the photo was taken or an expiration date.

Patient #5 was admitted August 7, 2008 and the patient record did not contain an identification photo.

When asked, staff confirmed that the narcotic treatment program does not maintain onsite an updated photograph taken every 3 years of each patient in treatment.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Due to some technical issues with our patient system, some patient pictures were deleted. The Front Office has went through each patient in the Tower system and documented which photos were missing. New photos were taken and uploaded to the system. Each six months, the Front Office staff will be responsible for taking new photos and uploading them to the system as well as taking a copy of the picture ID and place them in the patient file. There is not a place on the system to specific track when the photo was taken. Front Office will add to the note section of the Identification Page of when the photo was taken starting 3/31/2016.

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Based on a review of client records, the facility failed to document a timely treatment plan update in two of eight client records.

The findings include:

Twelve client records were reviewed on February 17-18, 2016. Eight client records were required to have a treatment plan update. The facility failed to document a treatment plan

Plan of Correction

There were four staff that were terminated/resigned between April - August of 2015. New staff were hired between August and November.

Starting 3/28/2016, when staff resign/terminate, Clinical Supervisors will audit each record to access paperwork that is needed, place a note to explain the gaps, then assign the patient to another Counselor to meet with the client within 30 days of the resignation/termination and complete all needed paperwork.

update in client records #2 and 11.

Client #2 was admitted on July 13, 2014. A treatment plan update was due by May 24, 2015 and was completed June 11, 2015. The next treatment plan update was due August 11, 2015 and was completed November 17, 2015. A treatment plan updated was not documented for January 2016.

Client #11 was admitted on October 1, 2015. The comprehensive treatment plan was completed on October 22, 2015. The treatment plan update was due December 22, 2015 and was completed on January 18, 2016.

These findings were reviewed with facility staff during the licensing process.

Clinical Supervisors will also doing a training on treatment planning on 03/28/2016.

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COATESVILLE TREATMENT CENTER

1825 EAST LINCOLN HIGHWAY
COATESVILLE, PA 19320

Survey conducted on 04/20/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 18-20, 2017 by staff from the Division of Drug and Alcohol Program Licensure, for the approval to use Methadone and Buprenorphine in the treatment of narcotic addiction. Based on the findings of the on-site inspection, Coatesville Treatment Center was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.9(c) LICENSURE Supervised Period

704.9. Supervision of counselor assistant. (c) Supervised period. (1) A counselor assistant with a Master's Degree as set forth in 704.8 (a)(1) (relating to qualifications for the position of counselor assistant) may counsel clients only under the close supervision of a trained counselor or clinical supervisor for at least the first 3 months of employment. (2) A counselor assistant with a Bachelor's Degree as set forth in 704.8 (a)(2) may counsel clients only under the close supervision of a trained counselor or clinical supervisor for at least the first 6 months of employment. (3) A registered nurse as set forth in 704.8 (a)(3) may counsel clients only under the close supervision of a trained counselor or clinical supervisor for at least the first 6 months of employment. (4) A counselor assistant with an Associate Degree as set forth in 704.8 (a)(4) may counsel clients only under the close supervision of a trained counselor or clinical supervisor for at least the first 9 months of employment. (5) A counselor assistant with a high school diploma or GED equivalent as set forth in 704.8 (a)(5) may counsel clients only under the direct observation of a trained counselor or clinical supervisor for the first 3 months of employment. For the next 9 months, the counselor assistant may counsel clients only under the close supervision of a lead counselor or a clinical supervisor.

Observations

Two personnel records were reviewed for the counselor assistant position on April 18, 2017. The facility failed to document the provision of direct observation for employee records # 12 and 13.

Employee # 12 was hired on 1/1/17 as a Bachelor's degree level counselor assistant. The employee requires close supervision for at least the first 6 months of employment. Weekly supervision notes were reviewed for the period of 1/5/17 - 3/30/17. The facility failed to demonstrate that weekly close supervision included an additional hour of direct observation at least once a week.

Employee # 13 was hired on 5/9/16 as a Bachelor's degree level counselor assistant. The employee required close supervision for at least the first 6 months of employment. Weekly supervision notes were reviewed for the period of

Plan of Correction

The Clinical Supervisor added a section on the Clinical Supervision Tracking sheet that clearly identifies direct observations. The Clinical Supervisors will be responsible for ensuring this updated form is used for any new hired Counselor Assistants. All new hired Counselor Assistants will meet with Clinical Supervisors for weekly supervision in addition to a direct observation. This information will be maintained and tracked by the Clinical Supervisors weekly. This will begin on 6/19/2017.

5/18/16 - 11/30/16. The facility failed to demonstrate that weekly close supervision included an additional hour of direct observation at least once a week.

These findings were reviewed with facility staff during the licensing inspection.

704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Observations

Thirteen personnel records were reviewed on April 18, 2017. The facility failed to provide documentation of completed HIV/AIDS training for employee # 10.

Employee # 10 was hired as a counselor on 11/16/15. HIV/AIDS training was due to be completed no later than 11/16/16. Completion of this training was not documented in the employee's record.

This finding was reviewed with facility staff during the licensing inspection.

This is a repeat citation, as the facility was previously cited for noncompliance of this standard during the previous licensing renewal inspections, conducted on 2/18/16.

Plan of Correction

Employee #10 was scheduled for a HIV/AIDS Training that was cancelled and was unable to find another training within the local area. Employee and Clinical Supervisors will continue to check the DDAP training system for upcoming trainings in the area. An approved training outside of DDAP will be utilized if nothing is added to the schedule by 6/30/2017.

709.33 (a) LICENSURE Notification of termination.

§ 709.33. Notification of termination. (a) Project staff shall notify the client, in writing, of a decision to involuntarily terminate the client ' s treatment at the project. The notice shall include the reason for termination.

Observations

Twelve client records were reviewed on April 19-20, 2017. The facility failed to document that written notification of involuntary termination from treatment was provided to the client for client record # 7.

Client # 7 was admitted on 8/25/14 for methadone maintenance treatment and was involuntarily terminated from the facility on 1/17/17. The client's record did not contain documentation that the client was provided written notification of the facility's decision to involuntarily terminate the client's treatment.

This finding was reviewed with facility staff during the licensing inspection.

Plan of Correction

A new tracking sheet will be created for all involuntary termination by 06/30/017. The Clinical Supervisors will be responsible for updating and maintaining the tracking sheet. If someone is tapered involuntarily, they will be added to the list and the form will identify that a letter was generated to ensure nothing is missed. A copy of the letters will be kept with the tracking sheet. If a patient is tapered for physical violence/threats, drug sells on the premises and other behaviors under Regulation 715.21, they will be immediately discharged and provided with a copy of referrals and a letter explaining that they are being discharged for violation of 715.12 and will not have a fir hearing. All fairing requests will be given to Clinic Director and Program Specialist to schedule fair hearing meeting.

A Fair Hearing will be held within seven (7) working days from the time of the patient's request.

The Fair Hearing committees' decision will be rendered no later than three (3) working days following the date of the

hearing. The decision will be in writing and a copy of the Fair Hearing proceedings will be made available to the patient upon request. The Clinic Director and Program Specialist are responsible for sending the fair hearing response.

715.6(d) LICENSURE Physician Staffing

(d) A narcotic treatment program shall provide narcotic treatment physician services at least 1 hour per week onsite for every ten patients

Observations

An onsite licensing inspection was conducted on April 18-20, 2017. Based on the review of administrative documentation, the facility failed to continuously provide narcotic treatment physician services at least one hour per week onsite for every ten clients.

During the licensing process, weekly physician time sheets were reviewed for the time period of 11/1/16 - 3/30/17. Insufficient onsite physician hours were provided for one week out of the time period reviewed.

During the week of February 19-25, 2017, the patient census was 506. The facility was required to provide at least 50.6 physician hours onsite. There were 41.25 onsite physician hours documented for this week.

This finding was reviewed with facility staff during the licensing process.

Plan of Correction

To ensure there is always adequate coverage during medical staff vacation, Regional Director will work on contracting services with a NTP physician who can provide back up services for CTC programs throughout the Pennsylvania region for vacation/sick time. This will be done by 7/31/2017. The documentation of the back-up physician hours will be maintained by the Clinic Director in kept in a locked personnel file.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Eleven client records were reviewed for the Methadone and Buprenorphine maintenance activities on April 19-20, 2017. The facility failed to document a random urinalysis at least monthly for client records # 3 and 5.

Client # 3 was re-admitted for methadone maintenance treatment on 7/6/16, and was still active in treatment. Urinalysis drug-screen results for the month of January 2017 were not documented in the client's record.

Client # 5 was admitted for methadone maintenance treatment on 6/8/16, and was then transferred to another narcotic treatment program on 1/25/17. Urinalysis drug-screen results for the month of October 2016 were not documented in the client's record.

Plan of Correction

A new tracking sheet was developed by the Director on Nursing on 4/24/2017 as an additional measure to ensure monthly urine drug screens are not missed. The assigned Dispensing Nurse is responsible for tracking the sheet weekly and rescheduling urinalysis that auto-failed in the system. The Urine Drug Screens that were not given were missed by oversight on the Auto-Fail report from the Dispensing System. Going forward, the new tracking sheet will helped to ensure no urine drug screens are missed.

The findings were reviewed with facility staff during the licensing inspection.

715.19(1) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (1) A narcotic treatment program shall provide each patient an average of 2.5 hours of psychotherapy per month during the patient 's first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations

Eleven client records were reviewed for the Methadone and Buprenorphine maintenance activities on April 19-20, 2017. The facility failed to document the provision of 2.5 hours of psychotherapy per month, to include 1 hour of individual psychotherapy, for client records # 3, 5, and 9.

Client # 3 was admitted on 7/6/16 for methadone maintenance treatment, and was still active in treatment. Documentation in the client's record indicated that for the period of October 2016 - December 2016, the client received 4.375 hours of psychotherapy, an average of 1.46 hours per month. In addition, for the period of January 2017 - March 2017, the client received 5.5 hours of psychotherapy, an average of 1.83 hours per month.

Client # 5 was admitted on 6/8/16 for methadone maintenance treatment, and was then transferred to another narcotic treatment program on 1/25/17. Documentation in the client's record indicated that for the period of July 2016 - August 2016, the client received 6.5 hours of psychotherapy, an average 2.17 hours per month. In addition, for the period of October 2016 - December 2016, the client received 6.17 hours of psychotherapy, an average of 2.06 hours per month.

Client # 9 was admitted on 12/8/16 for buprenorphine maintenance treatment, and was still active in treatment. Documentation in the client's record indicated that for the period of January 2017 - March 2017, the client received 6 hours of psychotherapy, an average of 2 hours per month. In addition, the client's record indicated that client did not receive 1 hour of individual psychotherapy in the month on March 2017.

These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

On 5/1/2017, Clinical Supervisors developed a new tracking sheet to closely monitor counseling hours. Each week counselors have to submit their counseling hours. Patients that missed counseling will be held to meet with a member of the clinical team prior to medicating to address issues of counseling non-compliance. Continued issues of counseling non-compliance after multiple intervention attempts will be moved to administrative taper. Clinical Supervisor will be responsible for monitoring counseling hours week over week.

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Twelve client records were reviewed on April 19-20, 2017. The facility failed to consistently document a treatment plan update at least every 60 days for client records # 3, 5, 7, 11, and 12.

Plan of Correction

On August 11th, the facility will have a new Electronic Medical Record that is completely electronic. It will enable Clinical Supervisors to closely monitor clinical documentation. The system is designed to show upcoming due dates for treatment plans. Clinical Supervisor will use the reporting capabilities in this system to ensure that Counselors are meeting with patients in the required time

Client # 3 was admitted into treatment on 7/6/16 and was still active in treatment. The first treatment plan update documented in the client's record was completed on 3/28/16. The subsequent treatment plan update was completed on 9/30/16. The following treatment plan updates documented in the client's record were completed on 11/11/16, 1/24/17, and 3/31/17.

Client # 5 was admitted into treatment on 6/8/16, and was transferred to another narcotic treatment program on 1/25/17. The first treatment plan update documented in the client's record was completed on 10/31/16. The subsequent treatment plan update was due to be completed by 12/31/16, and one was not documented in the client's record.

Client # 7 was admitted into treatment on 8/25/14, and was discharged on 1/17/17. A treatment plan update was completed for the client on 4/27/16. The subsequent treatment plan update documented in the client's record was completed on 7/27/16.

Client # 11 was admitted into treatment on 9/3/15 and was discharged on 3/16/17. A treatment plan update was completed for the client on 3/15/16. The subsequent treatment plan update documented in the client's record was completed on 6/1/16.

Client # 12 was admitted into treatment on 1/28/16 and was discharged on 6/22/16. A treatment plan update was completed for the client on 3/22/16. A subsequent treatment plan update was due to be completed for the client by 5/22/16, and one was not documented in the client's record.

This finding was reviewed with facility staff during the licensing process.

This is a repeat citation, as the facility was previously cited for noncompliance of this standard during the previous licensing renewal inspections, conducted on 2/18/16.

frames for their treatment plan updates. Patients that miss appointments will be held prior to medicating and will be given a non-complaint treatment plan to sign as needed. Until the system is created, the Clinical Supervisors will utilize a manually tracking sheet to track treatment plans to ensure they are completed before the due date. Treatment plans will continue to be done based on time in treatment. The Clinical Team will meet on 6/19/2017 during Clinical Supervision to receive training on the treatment plan process including ways to avoid missing treatment plan due dates.

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COATESVILLE TREATMENT CENTER

1825 EAST LINCOLN HIGHWAY
COATESVILLE, PA 19320

Survey conducted on 04/11/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 9-11, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Coatesville Treatment Center, was found to be not in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection.

Plan of Correction

704.11(d)(2) LICENSURE Annual Training Requirements

704.11. Staff development program. (d) Training requirements for project directors and facility directors. (2) A project director and facility director shall complete at least 12 clock hours of training annually in areas such as: (i) Fiscal policy. (ii) Administration. (iii) Program planning. (iv) Quality assurance. (v) Grantsmanship. (vi) Program licensure. (vii) Personnel management. (viii) Confidentiality. (ix) Ethics. (x) Substance abuse trends. (xi) Developmental psychology. (xii) Interaction of addiction and mental illness. (xiii) Cultural awareness. (xiv) Sexual harassment. (xv) Relapse prevention. (xvi) Disease of addiction. (xvii) Principles of Alcoholics Anonymous and Narcotics Anonymous.

Observations

Based on a review of employee training files conducted on April 9, 2018, the facility failed to document that the project director completed the required number of training hours.

Employee #1 was hired as the Projected Director on 11/1/16. Training certificates were reviewed for the period from January 1, 2017 through December 31, 2017; Employee #1 had documented only 6.28 hours of trainings at the time of the licensing inspection.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

An approved Plan of Correction is not on file.

705.28 (d) (1) LICENSURE Fire safety.

705.28. Fire safety. (d) Fire drills. The nonresidential facility shall: (1) Conduct unannounced fire drills at least once a month.

Observations

Based on a review of the fire drill record, conducted on April 9, 2018, the facility failed to document a fire drill for December 2017.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

Clinical Supervisor is the appointed Health & Safety Liaison. Due to inclement weather, one of the drills were missed; two fire drills were conducted in January 2018 to address the miss. The Clinical Supervisor has created a new tracking system to ensure that there are no drills missed even during inclement weather. It is now being tracked on a monthly calendar.

705.28 (d) (4) LICENSURE Fire safety.

705.28. Fire safety. (d) Fire drills. The nonresidential facility shall: (4) Maintain a written fire drill record including the date, time, the amount of time it took for evacuation, the exit route used, the number of persons in the facility at the time of the drill, problems encountered and whether the fire alarm or smoke detector was operative.

Observations
Based on a review of the fire drill record, conducted on April 9, 2018, the facility failed to document the number of persons in the facility on a fire drill record dated October 31, 2017, and whether the fire alarm or smoke detector was operative on a fire drill record dated January 23, 2017.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction
An approved Plan of Correction is not on file.

709.26 (b) (3) LICENSURE Personnel management.

§ 709.26. Personnel management. (b) The personnel records must include, but are not limited to: (3) Annual written individual staff performance evaluations, copies of which shall be reviewed and signed by the employee.

Observations
Based on a review of employee files conducted on April 9, 2018, the facility failed to ensure that each employee was given an annual work performance evaluation.

Employee #1 was hired as the Projected Director on 11/1/16. An annual work performance evaluation was last documented on 5/10/16; another annual performance evaluation was due to be completed by 5/10/17 but was not documented.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction
An approved Plan of Correction is not on file.

709.30 (1) LICENSURE Client rights

§ 709.30. Client rights. The project shall develop written policies and procedures on client rights and document written acknowledgement by clients that they have been notified of those rights. (1) A client receiving care or treatment under section 7 of the act (71 P. S. § 1690.107) shall retain civil rights and liberties except as provided by statute. No client may be deprived of a civil right solely by reason of treatment.

Observations
Facility policy and procedure manual was reviewed on April 9, 2018. The facility policy failed to include the following elements with regard to client rights:

(3) Clients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record.

(4) Clients have the right to appeal a decision limiting access to their records to the director.

(5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records.

(6) Clients have the right to submit rebuttal data or memoranda to their own records.

Plan of Correction
An approved Plan of Correction is not on file.

These findings were reviewed with facility staff during the licensing process.

715.6(d) LICENSURE Physician Staffing

(d) A narcotic treatment program shall provide narcotic treatment physician services at least 1 hour per week onsite for every ten patients

Observations

Based on a review of the physician and physician assistant schedules conducted on April 10, 2018, the facility failed to provide narcotic treatment physician services at least 1 hour per week onsite for every ten patients.

A schedule was submitted that indicated the hours worked for the physician and the physician extender staff, as well as the patient census, for the period from October 29, 2017 through March 31, 2018. The facility was not in compliance for the following weeks:

November 12-November 18, 2017: census 503, coverage 49.75 hrs

November 19-November 25, 2017: census 522, coverage 28 hrs

November 26-December 2, 2017: census 519, coverage 49.58 hrs

December 10, 2017- December 16, 2017: census 524, coverage 49.25 hrs

December 17, 2017- December 23, 2017: census 527, coverage 50.75 hrs

December 24, 2017- December 30, 2017: census 524, coverage 17 hrs

December 31, 2017- January 6, 2018: census 522, coverage 49.5 hrs

January 7, 2018-January 13, 2018: census 522, coverage 49.5 hrs

January 14, 2018-January 20, 2018: census 523, coverage 50.25 hrs

January 21, 2018-January 27, 2018: census 522, coverage 50 hrs

January 28, 2018-February 3, 2018: census 522, coverage 49.25 hrs

February 4, 2018-February 10, 2018: census 521, coverage 49.75 hrs

February 11, 2018-February 17, 2018: census 519, coverage 50.25 hrs

February 18, 2018-February 24, 2018: census 511, coverage 50.5 hrs

February 25, 2018-March 3, 2018: census 510, coverage 49.5 hrs

March 4, 2018-March 10, 2018: census 513, coverage 49.5 hrs

Plan of Correction

An approved Plan of Correction is not on file.

March 11, 2018-March 17, 2018: census 515, coverage 49.25 hrs

March 18, 2018-March 24, 2018: census 515, coverage 50 hrs

March 25, 2018-March 31, 2018: census 516, coverage 24 hrs

This information was reviewed with the facility staff during the licensing inspection.

715.6(e) LICENSURE Physician Staffing

(e) A physician assistant or certified registered nurse practitioner may perform functions of a narcotic treatment physician in a narcotic treatment program if authorized by Federal, State and local laws and regulations, and if these functions are delegated to the physician assistant or certified registered nurse practitioner by the medical director, and records are properly countersigned by the medical director or a narcotic treatment physician. One-third of all required narcotic treatment physician time shall be provided by a narcotic treatment physician. Time provided by a physician assistant or certified registered nurse practitioner may not exceed two-thirds of the required narcotic treatment physician time.

Observations

Based on a review of the physician and physician assistant schedules conducted on April 10, 2018, the facility failed to ensure that a narcotic treatment physician provided at least one third of the required physician time.

A schedule was submitted that indicated the hours worked for the physician and the physician extender staff, as well as the patient census, for the period from October 29, 2017 through March 31, 2018. The facility was not in compliance for the following weeks:

December 24, 2017- December 30, 2017: census 524, coverage 17 hrs

all conducted by physician assistant.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

An approved Plan of Correction is not on file.

715.23(b)(5) LICENSURE Patient records

(b) Each patient file shall include the following information: (5) The results of all annual physical examinations given by the narcotic treatment program which includes an annual reevaluation by the narcotic treatment physician.

Observations

Six methadone client records were reviewed on April 11, 2018, the facility failed to conduct an annual physical examination on time for client #3.

Client #3 was admitted on 10/9/16 and was an active client at the time of the licensing inspection.

An annual physical exam was conducted on 2/21/17; the annual physical exam was due to be completed by 2/21/18 but had not been completed at the time of the licensing inspection.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

An approved Plan of Correction is not on file.

715.28(a)(1-10) LICENSURE Unusual incidents

(a) A narcotic treatment program shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault by a patient. (2) Inappropriate behavior by a patient causing disruption to the narcotic

treatment program. (3) Selling of drugs on the premises. (4) Complaints of patient abuse (physical, verbal, sexual and emotional). (5) Death or serious injury due to trauma, suicide, medication error or unusual circumstances. (6) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (7) Incident with potential for negative community reaction or which the facility director believes may lead to community concern. (8) Theft, burglary, break-in or similar incident at the facility. (9) Drug related hospitalization of a patient. (10) Other unusual incidents the narcotic treatment program believes should be documented.

Observations

The facility's policy and procedure manual was reviewed on April 9, 2018. The policy failed to include the following elements with regard to the reporting of unusual incidents:

(9) Drug related hospitalization of a patient.

(10) Other unusual incidents the narcotic treatment program believes should be documented.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

An approved Plan of Correction is not on file.

709.92(a) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (a) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:

Observations

Seven client records were reviewed on April 11, 2018, the facility failed to document a comprehensive treatment plan or that the plan was developed with the client in records, #2 & 5.

Client #2 was admitted on 11/14/17 and was an active client at the time of the licensing inspection. The comprehensive treatment plan was not documented at the time of the licensing inspection.

Client #5 was admitted on 10/24/17 and discharged on 1/25/18. The comprehensive treatment plan was listed as having a due date of 11/24/17 in the electronic records system but was not documented until 1/2/18; additionally this document was not signed by the client and no other documentation was found in the record to indicate that the plan was developed with the client.

This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

An approved Plan of Correction is not on file.

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Seven client records were reviewed on April 11, 2018, the facility failed to update the treatment plan every 60 days in client records, #1, 4, 6 & 7.

Client #1 was admitted on 8/1/11 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 5/1/17; a treatment plan update was due by 9/1/17 but was not documented until 9/5/17.

Plan of Correction

An approved Plan of Correction is not on file.

Client #4 was admitted on 11/22/16 and discharged on 3/6/18. A treatment plan update was documented on 11/21/17; a treatment plan update was due by 1/21/18 but was not documented until 1/23/18.

Client #6 was admitted on 9/6/16 and discharged on 3/27/18. A treatment plan update was documented on 8/18/17; a treatment plan update was due by 10/18/17 but was not documented until 11/7/17; additionally, another treatment plan update was due by 1/7/18 but was not documented until 1/23/18.

Client #7 was admitted on 4/19/17 and discharged on 8/16/17. A comprehensive treatment plan was documented on 8/24/17; a treatment plan update was due by 10/24/17 but was not documented until 10/31/17.

This information was reviewed with the facility staff during the licensing inspection.

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