Pennsylvania Department of Health
Inspection Results

Surveys don't appear on this website until at least 41 days have elapsed since the exit date of the survey.

HABIT OPCO, INC.
118 MONAHAN AVENUE
DUNMORE, PA 18512

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 09/10/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on September 8, 2015 through September 10, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc. 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 a review of the project's Staffing Requirement Facility Summary Reports (SRFSR), the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings inclued:

The Staffing Requirements Facility Summary Reports for the 4 facilities contained within the project were reviewed on September 8, 2015. The equivalent of 22 full-time counselors were employed within the project at the time of the inspection. This would require at least 2 full-time clinical supervisor.

The project's SRFSRs listed a total of 2 clinical supervisors, who also were listed as counselors and having a full caseload; therefore, they are unable to provide full-time clinical supervision.

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

Plan of Correction

The Center Director will submit a Personnel Action Request to human resources on 10/12/15. This Personnel Action Request being submitted to hire an additional clinician, or counselor assistant. This staffing action will allow for the existing clinical supervisors caseload to be transferred to the new hire, while also ensuring that the counselor?s caseload does not exceed 35:1. When the hiring process is completed, this will create a dynamic for greater supervision and case review by the clinical supervisors, who will carry a caseload of no more than 5 patients. The Center Director will be responsible for ensuring that the action plan is implemented as well as continuously monitor the 8:1 counselor to clinical supervisor ratio, with the clinical supervisor, to ensure that the facility maintains compliance with the regulated ratio.

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 training records, the facility failed to document the completion of 25 clock hours of annual training required for counselors in three of seven personnel records reviewed.

The findings include:

Seven personnel records were reviewed on September 8, 2015. Six personnel records pertained to counselors with the requirement of the completion of 25 clock hours of annual training. The facility failed to document 25 clock hours of annual training in personnel records, #2, 6, and 7.

The project's training year was from January 1, 2014 through December 31, 2014.

Employee #2 was hired as a counselor on April 1, 2012 and was still in that position at the time of the inspection. There was only 10 clock hours of training documented in the employee file for the 2014 training year.

Employee #6 was hired as a counselor on October 1, 2012 and was still in that position at the time of the inspection. There was only 15 clock hours of training documented in the employee file for the 2014 training year.

Employee #7 was hired as a counselor on November 18, 2013 and was still in that position at the time of the inspection. There was only 16.5 clock hours of training documented in the employee file for the 2014 training year.

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

Plan of Correction

The Center Director will ensure that quarterly reviews are conducted to ensure that clinical personnel are on track with expected annual trainings.

The use of a tracking mechanism will be assigned to ensure that staff progress may be self monitored and reviewed on a regular basis.

Oversight to staff compliance will be delegated to thier direct report(s) and Administrative support staff.

The aforementioned will be presented to all staff during the October 14, 2015 staff meeting. Additionally, at that same time, a review of trainings completed for this year will be conducted with the opportunity for staff to complete and fill in thier training tracker tool.

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 the review of client records, the facility failed to

Plan of Correction

The Center Director intends to work with IT to have the

ensure that a complete, informed and voluntary consent to release information form was obtained in three of seventeen client records reviewed.

The findings included:

Seventeen client records requiring complete informed and voluntary consent to release information forms were reviewed on September 8, 2015 through September 10, 2015. The facility failed to ensure that the person to whom the disclosure was made and the signature and date of the witness were completed on the consent to release information form in client records #1, 2, and 6.

Client #1 was admitted into treatment on October 17, 2014 and was still an active client at the time of the inspection. A release of information to the emergency contact was signed and dated by the client on 10/17/14; however; the release of information form did not include the signature and the date of the witness at the time of the inspection.

Client #2 was admitted into treatment on August 25, 2015 and was still an active client at the time of the inspection. A release of information to the emergency contact was signed and dated by the client on 8/25/15; however; the release of information form did not include the signature and the date of the witness, the purpose of the disclosure, and the person to whom the disclosure was made to at the time of the inspection.

Client #6 was admitted into treatment on December 11, 2014 and was still an active client at the time of the inspection. A release of information to the emergency contact was signed and dated by the client on 10/17/14; however; the release of information form did not include the signature and the date of the witness at the time of the inspection.

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

Emergency Contact Releases prepared within the Center's Electronic Health Record (EHR), SMART.

With this document being placed into SMART. The existing admission procedures on site via the EHR require that all such documents to be completed, in their entirety, in order to move forward with the admission process.

A request for such and adjustment to the EHR and the inclusion of this docuemnt has been submitted as of this redraft.

Completion of this adjusment will be available and noted within patient records.

All existing records as identified via this audit will be corrected with the developing of a new emergency contact release to include the emergency contact information, signed by the patient and authorized staff witness. This effort will be completed by 10/9/2015.

709.28(d) LICENSURE Confidentiality

709.28. Confidentiality. (d) A copy of a client consent shall be offered to the client and a copy maintained in the client records.

Observations

Based on the review of client records, the facility failed to ensure that a copy of the signed client consent was offered to the client in six of seventeen client records reviewed.

The findings included:

Plan of Correction

The Center Director intends to work with IT to have the Emergency Contact Releases prepared within the Center's Electronic Health Record (EHR), SMART.

Part of the IT request will be to add a check box

acknowledging a patients response to the offering of a copy of said release/authorization.

Seventeen client records requiring informed and voluntary consent to release information forms were reviewed on September 8, 2015 through September 10, 2015. The facility failed to document that the signed consent forms were offered to the client in client records, #1, 2, 3, 6, 9, and 10.

With this document being placed into SMART and the admission procedures on site, it will prove necessary for all such documents to be completed in their entirety in order to move forward with the admission process.

Client #1 was admitted into treatment on October 17, 2014 and was still an active client at the time of the inspection. There was a consent to release form to the emergency contact signed and dated on 10/17/14 that did not include documentation that the client was offered a copy of each form.

A request for such and adjustment to the EHR and the inclusion of this docuemnt has already been submitted to IT.

All existing records as identified via this audit will be corrected with the developing of a new emergency contact release to include the emergency contact information, signed by the patient and authorized staff witness; and the inclusion of a written statement as to the offering of a copy of said release to the patient and their response.

Client #2 was admitted into treatment on August 25, 2015 and was still an active client at the time of the inspection. There was a consent to release form to the emergency contact signed and dated on 8/25/15 that did not include documentation that the client was offered a copy of each form.

This effort will be completed by 10/9/2015.

Client #3 was admitted into treatment on April 10, 2015 and was still an active client at the time of the inspection. There was a consent to release form to the emergency contact signed and dated on 4/6/15 that did not include documentation that the client was offered a copy of each form.

Client #6 was admitted into treatment on December 11, 2014 and was still an active client at the time of the inspection. There was a consent to release form to the emergency contact signed and dated on 12/8/14 that did not include documentation that the client was offered a copy of the consent to release form.

Client #9 was admitted into treatment on November 18, 2014 and was discharged on May 21, 2015. There was a consent to release form to the emergency contact signed and dated on 11/14/14 that did not include documentation that the client was offered a copy of the consent to release form.

Client #10 was admitted into treatment on June 24, 2014 and was discharged on October 3, 2014. There was a consent to release form to the emergency contact signed and dated on 7/10/14 that did not include documentation that the client was offered a copy of the consent to release form.

These 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 review and update the treatment and rehabilitation plan within the regulatory 60 day timeframe in two of three client records reviewed.

The findings include:

Three client records requiring updated treatment and rehabilitation plans within 60 days were reviewed on September 8, 2015 through September 10, 2015. The facility failed to document updated treatment plans within 60 days in client records,# 8 and 16.

Client #8 was admitted into outpatient treatment on February 17, 2015 and was still an active client as of the date of the on-site inspection. There was a treatment plan update completed on 04/27/2015 and another update was due no later than 06/27/2015; however, the treatment plan was completed after the 60 day regulatory timeframe on 07/22/2015.

Client #16 was admitted into outpatient treatment on July 1, 2014 and was discharged on June 24, 2015. There was a treatment plan update completed on 02/28/2015 and another update was due no later than 04/28/2015; however, the treatment plan was completed after the 60 day regulatory timeframe on 06/19/2015.

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

Plan of Correction

The Center Director will meet with the Senior Clinician to ensure that a more thorough review is conducted of Pt. charts and that clinical staff are utilzing the tools available to them via the EHR so that the timely completion of such documentation is accomplished.

As discussed during the licensing visit process related to this matter, if/when such a Pt. may be indisposed due to confinement/incarceration, notation will be made at the appropirate 60 day mark on the Tx plan; specifically on the 'Progress since last Plan' line, to infer that the plan remains "as is"...pending Pt.'s return to treatment from confinement/incarceration. Thereby ensuring that said observation is resolved.

709.92(c) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan.

Observations

Based on a review of client records, the facility failed to assure that counseling services were provided according to the individual treatment and rehabilitation plan in two of three client records reviewed.

The findings include:

Three client records requiring assurance that counseling services are provide to the client as prescribed in the treatment and rehabilitation plan were reviewed on

Plan of Correction

The Center Director will review with the Senior Clinician and Clinical Team on October 14, 2015 the need to ensure that appropriate documentation is maintained with regards to Pt. compliance to Treatment plan expectations and session attendance.

The need to review treatment plan recommendations and/or patient accountatility will also be discussed. The need to modify one or the other so as to meet program and Patient needs will prove necessary.

September 8, 2015 through September 10, 2015. The facility failed to provide counseling services in accordance with the treatment plan in client records # 16 and 17.

On-going case consult sessions and MDT will be used to monitor said compliance to Tx and documentation as noted within this observation.

Client #16 was admitted into outpatient treatment on July 1, 2014 and was discharged on June 24, 2015. The client signed and dated the treatment plan on 8/1/2015, which indicated that the client was to receive group sessions once a week. The client's last group attendance was documented on 03/28/2015; therefore, for the months of April, May, and June 2015 there was no documentation of attendance, no shows/cancellations, or whether the client was stepped down from that service in the client chart at the time of the inspection.

Client #17 was admitted into outpatient treatment on July 10, 2014 and was discharged on November 20, 2014. The client signed and dated the treatment plan on 8/4/2015, which indicated that the client was to receive group sessions once a week. The client should have attended four times per month; however, attendance was only documented for one session in October 2014 and one session in November 2014 with no documentation of attendance, no shows/cancellations.

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

709.93(a) LICENSURE Client records

709.93. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following:

Observations

Based on a review of client records, the facility failed to document a complete client record on an individual, which includes case consultation notes and follow-up information in two of three client records reviewed.

The findings include:

Three client records requiring a complete client record on an individual were reviewed on September 8, 2015 through September 10, 2015. The facility did not provide a complete client record for clients, #16 and 17.

Client #16 was admitted into outpatient treatment on July 1, 2014 and was discharged on June 24, 2015. The facility failed to include documentation of any case consultation notes in the client record at the time of the inspection.

Client #17 was admitted into outpatient treatment on July

Plan of Correction

During the October 14, 2015 all staff meeting a review of Case Conlsultations and discharged patient follow up procedures will be discussed; along with a review of the on-site Policy to the same.

Staff assignments will be revised to ensure compliance to a timely attention to both of these clinical procedures.

The Center Director will also reach out to IT to ascertain if these services may be 'called up' via the EHR with a reminder notification to assigned staff. If so, such a modification will be added to the EHR so that the discharging Primary Clinician is provided with a timely reminder of this service due so that it may be completed and documented as such.

Additionally, clinical and administrative staff will utilize a basic excel table to track services due, such as case consult and discharge follow up contacts. The table will be part of each staff members weekly review for completion and will be part of supervisory discussions and review for completion.

The aforementioned template will be prepared and presented to all staff during the Oct. 14 staff meeting.

10, 2014 and was discharged on November 20, 2014. The facility failed to include documentation of any case consultation notes in the client record at the time of the inspection. Additionally, the facility failed to include documentation of follow-up information after the client was discharged.

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

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Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/13/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted from October 11, 2016 to October 13, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Habit OPCO, Inc. 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 the inspection:

Plan of Correction

704.5(c) LICENSURE Qualifications for Proj/Fac Dir

704.5. Qualifications for the positions of project director and facility director. (c) The project director and the facility director shall meet the qualifications in at least one of the following paragraphs: (1) A Master's Degree or above from an accredited college with a major in medicine, chemical dependency, psychology, social work, counseling, nursing (with a specialty in nursing/health administration, nursing/counseling education or a clinical specialty in the human services), public administration, business management or other related field and 2 years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service and program planning. (2) A Bachelor's Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a specialty in nursing/health administration, nursing/counseling education or a clinical specialty in the human services), public administration, business management or other related field and 3 years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service and program planning. (3) An Associate Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a specialty in nursing/health administration, nursing/counseling education or a clinical specialty in the human services), public administration, business management or other related field and 4 years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service and program planning.

Observations
Based on a review of personnel records on October 11, 2016, it was determined that the project director of the facility did not meet the experiential requirements for the position. Considering the educational attainment of the current project director, he is required to have at least three years of experience in a human service agency, which includes supervision, direct service, and program planning. At the time of the inspection, the project director had no documented experience providing direct services.

Plan of Correction
The Project Director role will be transition to Jonathon Wasp effective 11/14/2016. Mr. Wasp meets all of the qualifications identified in the regulations including direct service. A formal notification will be submitted to the department by Mr. Wasp along with supporting documentation validating his qualifications for the role.

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

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

A review of the September 2015 through September 2016 fire drill logs was conducted during the onsite inspection. The facility failed to conduct unannounced drills during the 2016 months of April, May, June, August, and September. Additionally, the logs for the months of January 2016, February 2016, March 2016, and July 2016 failed to include the number of persons in the facility at the time of the drill and whether a fire alarm or smoke detector was operative at the time of the drill. Also, the logs for the months of January 2016, February 2016, March 2016, and July 2016 failed to include the exit route used.

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

Plan of Correction

A review of the same was conducted by the Center Director and the Safety Committee members on Friday, October 14, 2016. Corrections and training offered to all staff related to the same during a supervisory meeting with the Admin. Asst., Security and Safety committee members held on Monday October 17, 2016. A thorough review to adhere to the 'most stringent' policy completed and corrections made to the same.

During this training, and subsequent supervisory meeting(s), Security supervisor (Admin. Asst.) and the Clinical Supervisor, in concert with the Health & Safety committee members, will review and ensure that monthly drills are conducted as outlined in regulation P273. This will be an ongoing function and job duty of these management and Team members. A further presentation to all on site will be completed during the next monthly staff meeting on Thursday 11/17/2016.

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 the review of the physician timesheets for the months of July, August, September, and October 2016, the facility failed to provide at least one hour of physician time a week, on site for every ten patients during the month of July 2016 and the first week of August 2016.

During the week of July 3-9, 2016, the patient census was 273. The facility was required to provide at least 27.3 physician hours. There were 9 physician hours documented.

During the week of July 10-16, 2016, the patient census was 274. The facility was required to provide at least 27.4 physician hours. There were 12 physician hours documented.

During the week of July 17-23, 2016, the patient census was 278. The facility was required to provide at least 27.8 physician hours. There were 12 physician hours documented.

During the week of July 24-30, 2016, the patient census was 273. The facility was required to provide at least 27.3 physician hours. There were 12 physician hours documented.

During the week of July 31, 2016 to August 6, 2016, the patient census was 277. The facility was required to provide at least 27.7 physician hours. There were 4 physician hours documented.

These findings were reviewed with facility staff during the

Plan of Correction

It is noted and known that during the period in question there may be a lapse in such coverage in order to on-board additional medical personnel to best meet the needs of our population. As such, the on-boarding of the new physician extender on August 8, 2016, did create an overlap to this coverage. As such it was discussed and noted during the audit, and at the time of the exit, that this matter has been corrected as of August 8, 2016; and Dunmore CTC is currently in compliance to the regulations.

Pursuant to this, and with the on-boarding of the CRNP-Physician Extender, it will be added to their duties to ensure on-going medical coverage remains adequate and meeting all of the requirements of M025. As dictated by the ratios contained therein, it will be the responsibility of the Center Director to ensure, if and when necessary, additional hours are added to either the existing Physicians and/or Physician Extender where appropriate to maintain compliance.

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

Based on a review of patient records, the facility failed to provide patient # ' s 1, 3, and 7 with 2.5 hours of psychotherapy per month during the patient ' s first 2 years of treatment.

Patient # 1 was admitted on April 9, 2015 and discharged on September 26, 2016. In July 2016, the patient had 30 minutes of individual therapy and 1.5 hours of group therapy. In August 2016, the patient had 30 minutes of individual therapy and 0 hours of group therapy. There was no documentation of patient no shows or cancellations during those time periods.

Patient # 3 was admitted on April 28, 2016 and was an active patient at the time of inspection. In July 2016, the patient had one hour of individual therapy and 0 hours of group therapy. In August 2016, the patient had 0 hours of individual therapy and 0 hours of group therapy. In September 2016, the patient had 30 minutes of individual therapy and 0 hours of group therapy. There was no documentation of patient no shows or cancellations during those time periods.

Patient # 7 was admitted on February 4, 2016 and was discharged on July 28, 2016. In April 2016, the patient had 0 hours of individual therapy and 0 hours of group therapy. In May 2016, the patient had 1 hour of individual therapy and 0 hours of group therapy. In June 2016, the patient had 0 hours of individual therapy and 1.5 hours of group therapy. There was no documentation of patient no shows or cancellations during those time periods.

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

Plan of Correction

A thorough review of Pt. engagement and services rendered with the Center Director, Clinical Supervisor and the Clinical Team has commenced as of October 14, 2016 in response to the comments noted to 715.19(1). Based on existing staffing needs, at the time in question, there had been significant staffing pattern changes and adjustments made during the time period in question; as noted and reviewed during this audit and exit; in order to address the same. Dunmore CTC being re-staffed fully as of September 21, 2016, along with on-going weekly Clinical Team meetings and tracking mechanisms being placed into action as a result of these findings, it is expected that such matters will be corrected. On-going meetings with the Center Director & Clinical Supervisor, along with the Regional Clinical Services Coordinator will ensure compliance to the same moving forward. A review of the progress to this end will be completed on November 30, 2016 with the anticipation of observable corrective trending.

715.28(c)(1-5) LICENSURE Unusual incidents

(c) A narcotic treatment program shall file a written Unusual Incident Report with the Department within 48 hours following an unusual incident including the following: (1) Complaints of patient abuse (physical, verbal, sexual and emotional). (2) Death or serious injury due to trauma, suicide, medication error or unusual circumstances. (3) Significant disruption of services due to a disaster such as a fire, storm, flood or other occurrence. (4) Incidents with potential for negative community reaction or which the facility director believes may lead to community concern. (5) Drug related hospitalization of a patient.

Observations

During the licensing inspection from October 11, 2016 to October 13, 2016, a review of fire drill logs was conducted. During the review, it was discovered that the facility had an

Plan of Correction

A review of the same was conducted by the Center Director and the Safety Committee members on Friday, October 14, 2016. Corrections and training offered to all staff during this

unusual incidents occur on February 28, 2016, March 10, 2016, April 7, 2016, and July 4, 2016, all of which required either fire, police, or ambulance personnel onsite. Upon further inspection, it was discovered that the facility had not submitted written unusual incident reports for any of the aforementioned incidents to the Department within the regulatory 48 hour timeframe.

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

supervisory meeting with the Admin. Asst., Security and Safety committee members held on Monday October 17, 2016. A review as to the ability for Security and Safety team members to use 'real scenarios' as evidence of Drills was confirmed, yet in such cases that warrant compliance to 715.28(c)(1-5) it is necessary to ensure such is brought to the attention of the CD in order to file the appropriate paperwork with the State. Those outstanding 'drill' scenarios that require the same will be filed with the State by Friday, November 4, 2016. Any and all such scenarios will be in full adherence to 715.28(c)(1-5) moving forward.

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 patient records, patient records #1, 3, 4, 6, 9, and 10 had treatment plan updates completed after the regulatory timeframe of 60 days at the time of the inspection.

Patient #1 was admitted on April 9, 2015 and was discharged on September 26, 2016. There was a documented treatment plan update completed on August 31, 2015 but no treatment and rehabilitation plan update until February 17, 2016.

Patient #3 was admitted on April 28, 2016 and was an active patient at the time of inspection. The comprehensive treatment and rehabilitation plan was completed on July 8, 2016 and the update was due no later than September 8, 2016; however, the update was not completed until September 29, 2016.

Patient #4 was admitted on April 14, 2015 and was discharged on August 25, 2016. A treatment plan update was due no later than November 16, 2015; however, the update was not completed until March 15, 2016.

Patient #6 was admitted on February 5, 2014 and was discharged on September 30, 2016. A treatment plan update was due no later than October 13, 2015; however, the update was not completed until March 31, 2016.

Patient #9 was admitted on October 16, 2012 and was an active patient at the time of the inspection. A treatment plan update was due to be completed by October 21, 2015 and the next update was not completed until February 9, 2016. The following treatment plan update was not completed until April 22, 2016.

Plan of Correction

A thorough review of Pt. engagement and services rendered with the Center Director, Clinical Supervisor and the Clinical Team has commenced as of October 14, 2016 in response to the comments noted to 709.92(b). Based on existing staffing at the time in question, there had been significant staffing pattern changes and adjustments made during the time period in question; as noted and reviewed during this audit and exit; in order to address the same. Dunmore CTC being re-staffed fully as of September 21, 2016, along with on-going weekly Clinical Team meetings and tracking mechanisms being placed into action as a result of these findings, it is expected that such matters will be corrected. On-going meetings with the Center Director & Clinical Supervisor, along with the Regional Clinical Services Coordinator will ensure compliance to the same moving forward. A review of the progress to this end will be completed on November 30, 2016 with the anticipation of observable corrective trending.

Patient #10 was admitted on June 21, 2012 and was an active patient at the time of the inspection. A treatment plan update was due to be completed by October 14, 2015 and the next update was not completed until February 19, 2016.

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

709.93(a) LICENSURE Client records

709.93. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following:

Observations

Based on a review of ten patient records, the facility failed to provide a complete patient record in patient records #4, 6, and 7.

Patient #4 was admitted on April 14, 2015 and was discharged on August 25, 2016. The patient record did not contain a discharge summary or any documentation of follow-up information as of the date of the inspection.

Patient #6 was admitted on February 5, 2014 and was discharged on September 30, 2016. The patient record did not contain any documentation of follow-up information as of the date of the inspection.

Patient #7 was admitted on February 4, 2016 and was discharged on July 28, 2016. The patient record did not contain a discharge summary or documentation of case consultation as of the date of the inspection.

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

Plan of Correction

A thorough review of Pt. engagement and services rendered with the Center Director, Clinical Supervisor and the Clinical Team has commenced as of October 14, 2016 in response to the comments noted to 709.93(a). Based on existing staffing at the time in question, there had been significant staffing pattern changes and adjustments made during the time period in question; as noted and reviewed during this audit and exit; in order to address the same. Dunmore CTC being re-staffed fully as of September 21, 2016, along with on-going weekly Clinical Team meetings and tracking mechanisms being placed into action as a result of these findings, it is expected that such matters will be corrected. On-going meetings with the Center Director & Clinical Supervisor, along with the Regional Clinical Services Coordinator will ensure compliance to the same moving forward. A review of the progress to this end will be completed on November 30, 2016 with the anticipation of observable corrective trending.

Pursuant to the ongoing reviews, the Clinical Supervisor will continue to conduct weekly and monthly reviews of all services necessary; including case consults. Additionally, the CS will conduct a review of post treatment documentation such as discharge summaries and follow-up contacts. The former will be assigned to the active PC in question. As was the case with in-completed discharge summaries during this audit period, if the staff member is no longer employed, the CS will make notation to such and notation to close out the discharge summary with as much detail and information that may be gleaned from their interactions with Pt., as may be ascertained from the Pt. record and in consult with the Multi-Disciplinary Team members.

As to the latter, Follow up contacts will be assigned by the CS to either the primary clinician and/or the Admissions team; these contacts to be documented with the EHR and noted accordingly.

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HABIT OPCO, INC.

118 MONAHAN AVENUE
DUNMORE, PA 18512

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 02/03/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on February 3, 2017 by staff from the Division Accountability and Program Improvement. Based on the findings of the investigation, Habit OPCO, Inc. 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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HABIT OPCO, INC.
118 MONAHAN AVENUE
DUNMORE, PA 18512

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/16/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on November 15-16, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc. 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

704.7(b) LICENSURE Counselor Qualifications

704.7. Qualifications for the position of counselor. (a) Drug and alcohol treatment projects shall be staffed by counselors proportionate to the staff/client and counselor/client ratios listed in 704.12 (relating to full-time equivalent (FTE) maximum client/staff and client/counselor ratios). (b) Each counselor shall meet at least one of the following groups of qualifications: (1) Current licensure in this Commonwealth as a physician. (2) A Master's Degree or above from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting. If the practicum did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues. (3) A Bachelor's Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 1 year of clinical experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues. (4) An Associate Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 2 years of clinical experience (a minimum of 3,640 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues. (5) Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing and 1 year of counseling experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues. (6) Full certification as an addictions counselor by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board.

Observations

Based on a review of personnel records conducted on November 15, 2017, the facility failed to ensure that all clinical staff met the requirements for their position.

Employee #9 was hired as high school level counselor assistant on 3/22/17. On September 10, 2017 was promoted to a counselor, however they did not have a qualifying degree in a related field.

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

Plan of Correction

Dunmore CTC will ensure that any such staffing transitions, that encourage and reward positive staff performance in the care and delivery of professional services are documented more thoroughly to ensure accurate representation to the same for regulatory bodies. A review of the necessary protocols to accurately represent the same has been presented and reviewed with the newly appointed clinical supervisor on November 30, 2017. The Staff member in question was re-classified to their previous job title of Counselor Asst. effective November 22, 2017. During this meeting the staff member was also supported with their application to the PA Certification Board. The staff member is prepared to take their Certification Examination as soon as it is scheduled via the PA Cert. Board. Upon successful

completion and acquisition of Certification, this staff member will be re-appointed to the position of Counselor et al. It is projected that such will completed by January 22, 2018. Any and all future such promotional recommendations for clinical staff members will require the presentation of all necessary data and supporting documentation to the Center Director and or their designee to ensure all areas of 704.7 are met prior to the actual promotion of same.

704.8(c) LICENSURE Full Caseload Assignment

704.8. Qualifications for the position of counselor assistant. (c) In addition to training, assignment of a full caseload shall be contingent upon the supervisor's positive assessment of the counselor assistant's individual skill level.

Observations

Based on a review of supervision files and personnel records on November 15, 2017, the facility failed to ensure that a counselor assistant received a positive assessment prior to the assignment of a full case load.

Employee #9 was hired as high school level counselor assistant on 3/22/17. There was no documentation of a positive assessment as a counselor assistant prior to assigning a full case load.

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

Plan of Correction

Dunmore CTC will ensure that any such staffing transitions, that encourage and reward positive staff performance in the care and delivery of professional services are documented more thoroughly to ensure accurate representation to the same for regulatory bodies. A review of the necessary protocols to accurately represent the same has been presented and reviewed with the newly appointed clinical supervisor on November 30, 2017. An additional review to support the documentation of a positive assessment being completed and filed in ones' personnel record was also completed on this date. Upon this staff members acquisition of their PA Certification, such documentation will be added to support this staff members re-appointment to the position of Counselor. It is projected that such will be resolved by January 22, 2018.

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

Based on a review of supervision log conducted on November 15, 2017, the facility failed to ensure that a counselor assistant received direct observation for the first three months of employment.

Employee #9 was hired as high school level counselor assistant on 3/22/17. A supervision log, which contains a column to denote when direct observation occurs, indicated that supervision was provided on 3/24/17, 3/29/17, 4/5/17, 4/12/17, 4/13/17, 4/18/17, 4/26/17, 4/27/17, 5/5/17, 5/17/17, 6/23/17, 6/27/17, 7/6/17, 7/12/17, 7/20/17, 7/26/17, 8/2/17, 8/11/17, 8/18/17, 8/24/17, 8/30/17, however none of the supervision was documented as direct observation.

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

Plan of Correction

Dunmore CTC clinical management team will ensure that if/when a counselor assistant is placed into a clinical position on site, that we adhere to the protocols as set forth by regulation 704.9 and as is present on the documentation on site that supports the same to ensure that Direct Observation is utilized as a clinical oversight and training of a counselor assistant within their role on site, during the first three (3) months; and beyond if necessary. A review of the protocol and regulation was presented by this author to the newly appointed clinical supervisor on November 30, 2017. This corrective measure is expected to be adhered to as of November 30, 2017 forward. Such documentations will be maintained in the staff members personnel record. This too was discussed and reviewed with the newly hired Office Mgr. on November 30, 2017.

704.10 LICENSURE Counselor Asst Promotion

704.10. Promotion of counselor assistant. (a) A counselor assistant who satisfactorily completes one of the sets of qualifications in 704.7 (relating to qualifications for the position of counselor) may be promoted to the position of counselor.

(b) A counselor assistant shall document to the facility director that he is working toward counselor status. This information shall be documented upon completion of each calendar year. (c) A counselor assistant shall meet the requirements for counselor within 5 years of employment. A counselor assistant who has accumulated less than 7,500 hours of employment during the first 5 years of employment will have 2 additional years to meet the requirements for counselor. (d) A counselor assistant who cannot meet the time requirements in subsection (c) may submit to the Department a written petition requesting an exception. The petition shall describe the circumstances that make compliance with subsection (c) impracticable and shall be approved by both the clinical supervisor or lead counselor and the project director. Granting of the petition will be within the discretion of the Department.

Observations

Based on a review of personnel records conducted on November 15, 2017, the facility failed to ensure that a counselor assistant satisfactorily completed the qualifications for counselor prior to promotion.

Employee #9 was hired as high school level counselor assistant on 3/22/17. On September 10, 2017 was promoted to a counselor, however employee #9 did not have a qualifying degree in a related field.

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

Plan of Correction

Dunmore CTC will ensure that any such staffing transitions, that encourage and reward positive staff performance in the care and delivery of professional services are documented more thoroughly to ensure accurate representation to the same for regulatory bodies. A review of the necessary protocols to accurately represent the same has been presented and reviewed with the newly appointed clinical supervisor on November 30, 2017. The Staff member in question was re-classified to their previous job title of Counselor Asst. effective November 22, 2017. During this meeting the staff member was also supported with their application to the PA Certification Board. The staff member is prepared to take their Certification Examination as soon as it is scheduled via the PA Cert. Board. Upon successful completion and acquisition of Certification, this staff member will be re-appointed to the position of Counselor et al. It is projected that such will completed by January 22, 2018. Any future such staffing adjustments will require the immediate supervisor to present any and all supporting data and documentation to the Center Director, and/or their designee, to ensure completion and adherence to this regulation prior to actual staffing promotional adjustments.

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 conducted on November 15, 2017, the facility failed to ensure that a counselor received the required 25 training hours during the training year from January 1, 2016 through December 31, 2016.

Employee #5 was hired as a counselor on April 29, 2013 and promoted to Lead Counselor on September 25, 2017. Training files were reviewed for the period from January 1, 2016 through December 31, 2016 . During that time employee #5 received only 10 documented hours of training.

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

Plan of Correction

Dunmore CTC Clinical Mgmt. team will ensure that each and every clinical staff member completes the required number of annual training's expected during a calendar year. The staff member in question is a licensed professional counselor as well as a certified substance abuse counselor who is required to maintain more than 60 hours of training's, albeit in a two (2) year period. As such, and as discussed and reviewed with the auditor, this staff member completed the majority of these training's during the current calendar period, with minimal attendance during the 2016 calendar period. A review of staff members needs to adhere to the appropriate level of training's each year, and to spread out said training's year over year, was presented and reviewed during the full staff monthly meeting held on December 6, 2017. This presentation also served as a reminder to all staff to be cognizant and aware of their annual training needs and ensure that such is provided to the Office Mgr. so that it may be accurately represented in ones' personnel file. As such, this date will also serve as the corrective action date to ensure adherence to 704.10.

704.12(a)(6) LICENSURE OutPatient Caseload

704.12. Full-time equivalent (FTE) maximum client/staff and client/counselor ratios. (a) General requirements. Projects shall be required to comply with the client/staff and client/counselor ratios in paragraphs (1)-(6) during primary care hours. These ratios refer to the total number of clients being treated including clients with diagnoses other than drug and alcohol addiction served in other facets of the project. Family units may be counted as one client. (6) Outpatients. FTE counselor caseload for counseling in outpatient programs may not exceed 35 active clients.

Observations

Based on a review of the Staffing Requirements Facility Summary Report conducted on November 15, 2017, the facility failed to ensure that employees #8 & 9 did not exceed 35 active clients.

Employee #8 works 37.5 hours and has 46 clients yielding a ratio of 43:1.

Employee #9 works 37.5 hours and has 47 clients yielding a ratio of 44:1.

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

Plan of Correction

Dunmore CTC Clinical Mgmt. completed a thorough review of the existing case loads and has corrected the ratio discrepancies noted herein. A review of such on November 30, 2017, as well as during the audit, demonstrated that their was the ability to have a balanced ratio with staff to patient ratio's. It is also noted that with Center continued growth, it is necessary to add additional clinical staffing. As such a position posting has been submitted and is presently running to seek out qualified clinical staff to join the Dunmore CTC team. Clinical Team leaders have been charged with maintaining an accurate assessment of the staff to Pt. ratio and to provide recommendations for adjustments and/or staffing additions to ensure compliance to 704.12. A full review was provided during the Monthly Staff meeting on December 6, 2017 which will serve as the corrective action date. Ongoing weekly reviews will be conducted by Clinical Team Leaders and the Clinical Supervisor with recommendations to be offered to the CD if/when necessary, yet in advance of non-compliance.

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 physican hours and a review of the physician's schedule conducted on November 15, 2017, 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 weeks from July 23, 2017 through November 10, 2017. The facility was not in compliance for the following weeks:

July 23-29-- census 333, coverage 29.5 hrs

August 20-26-- census 345, coverage 14.25 hrs

September 3-9-- census 357, coverage 27 hrs

September 17-23-- census 352, coverage 27.5 hrs

September 24-30-- census 354, coverage 25.5 hrs

October 1-7-- census 358, coverage 30.65 hrs

October 8-14-- census 360, coverage 26.25 hrs

October 15-21-- census 356, coverage 18.45 hrs

October 22-28-- census 358, coverage 29.5 hrs

October 29-November 4-- census 361, coverage 19.75 hrs

November 5-11-- census 361, coverage 22.25 hrs

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

Plan of Correction

Following the unexpected and untimely resignation of the Regional Medical Director for the HOI-Project in May 2017, this author immediately commenced a search for additional medical personnel to contract with for patient care. The intention of filling this position was focused on the most qualified and appropriate hire to ensure nothing short of exceptional patient care; such did take time. An additional Physician was identified and, following a lengthy contract development, has commenced services on site in Dunmore CTC prior to the audit. As this physician continues to acclimate to the Center and patients, an increase to their days/hours offered on site will also be realized. Such is planned for January 22, 2018. Such will place Dunmore CTC in compliance to this metric. Yet, with the projected census growth, based on trending data, it is necessary to seek additional medical personnel. As such, this author has commenced a search to add additional Physician Extender hours with the hire of an another physician extender. This process has commenced at the time of this draft. As the appropriate hire is necessary to ensure nothing short of exceptional patient care, it is expected that this process may take some time, yet is projected to be resolved and an additional extender added to the Center Medical Team by January 29, 2018.

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 physican hours and a review of the physician's schedule conducted on November 15, 2017, 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 weeks from July 30, 2017 through November 10, 2017. The facility was not in compliance for the following weeks:

July 23-29-- 10.9 required hours, 7.5 actual physician hours worked.

September 3-9-- 8.9 required hours, 0 actual physician hours worked.

October 15-21-- 6.1 required hours, 4 actual physician hours worked.

October 22-28-- 9.7 required hours, 4 actual physician hours worked.

October 29-November 4-- 6.5 required hours, 5.5 actual physician hours worked.

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

Plan of Correction

Following the unexpected and untimely resignation of the Regional Medical Director for the HOI-Project in May 2017, this author immediately commenced a search for additional medical personnel to contract with for patient care. The intention of filling this position was focused on the most qualified and appropriate hire to ensure nothing short of exceptional patient care; such did take time. An additional Physician was identified and, following a lengthy contract development, has commenced services on site in Dunmore CTC prior to the audit. As this physician continues to acclimate to the Center and patients, an increase to their days/hours offered on site will also be realized. Such is planned for January 22, 2018. Such will ensure that a narcotic treatment physician provide at least one third of the required physician time and place Dunmore CTC in compliance to this metric.

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

Seven client records were reviewed on November 16, 2017, four of which were methadone client records; the facility failed to document an average of 2.5. hours of psychotherapy per month in client records, #2 & 6.

Client #2 was admitted on 12/10/15 and was an active client at the time of the licensing inspection.

The facility documented no-show notes for individual sessions on 1/18/17, 2/2/17, 3/31/17, 5/11/17, 6/9/17, 7/10/17, 8/16/17, 9/11/17 9/18/17 and 11/6/17.

Client #2 attended a 60 minute individual session on 1/26/17 and a 30 minute session on 4/21/17; #2 also attended a 90 minute group on 1/25/17 and 8/19/17.

Client #6 was admitted on 12/13/16 and was discharged on 4/11/17.

The facility documented no-show notes for an individual session on 2/3/17, and an excused note for 1/27/17.

Plan of Correction

On November 30, 2017 this author completed a review of 715.19(1) with the Clinical Management Team. Mgmt. team members where instructed to identify procedures to correct the clinical engagement for patients on site, identifying processes by which this may be realized and be prepared to present their ideas and plans during our next Clinical Team meeting with, all clinical staff, on January 12, 2018. Addition of clinical team members, along with enhanced group offerings were placed on the table by this author during the Nov. 30th meeting. The entire clinical team will reconvene and implement final, mutually agreed to plans geared to increase and enhance clinical program offerings to fully commence on January 15, 2018. The submission of weekly Services Rendered will be submitted to the Weekly Supervisor, and/or their designee, to ensure accurate and timely engagement to patient care and needs on a regular and on-going basis.

Client #6 attended a 60 minute individual session on 2/1/17, 2/15/17 and 2/28/17.

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

715.23(b)(23) LICENSURE Patient records

(b) Each patient file shall include the following information: (23) Discharge summary.

Observations

Seven client records were reviewed on November 16, 2017, four of which were methadone client records; the facility failed to document a discharge summary in client record #6.

Client #6 was admitted on 12/13/16 and was discharged on 4/11/17.

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

Plan of Correction

On November 30, 2017 this author completed a review of 715.23(b)(23) with the Clinical Management Team. Mgmt. team members where instructed to commence a review, with their teams, all discharged patient records to ensure that there are no outstanding discharge summaries that remain incomplete. This responsibility to complete regular (Weekly or bi-weekly checks) on the same has been reassigned to the newly appointed clinical supervisor and the clinical team leaders to ensure timely completion to this, and any, clinical documentation that is required. Such corrections are to be completed by the clinical team meeting slated for January 12, 2018. A review of timely completion of the same will also be presented during this clinical team meeting to ensure compliance moving forward and that is sustainable with potential clinical staffing changes and caseload reassignments; as such may present itself.

715.23(b)(24) LICENSURE Patient records

(b) Each patient file shall include the following information: (24) Follow-up information regarding the patient.

Observations

Seven client records were reviewed on November 16, 2017, four of which were methadone client records; the facility failed to document a follow up information in client record #6.

Client #6 was admitted on 12/13/16 and was discharged on 4/11/17.

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

Plan of Correction

On November 30, 2017 this author completed a review of 715.23(b)(24) with the Clinical Management Team. Mgmt. team members where instructed to commence a review, with their teams, all discharged patient records to ensure and correct any outstanding follow up contacts in patient records.

This responsibility being shared with additional clinical team members and to be completed on a regular basis (Weekly or bi-weekly). A review of this has been assigned to the newly appointed clinical supervisor and clinical team leaders to ensure timely completion and documentation to all follow up patient contacts post discharge. Such corrections are to be completed by the clinical team meeting slated for January 12, 2018. A review of timely completion of the same will also be reviewed during this clinical team meeting and full staff meeting, to ensure compliance moving forward.

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 November 16, 2017, four of which were methadone client records; the facility failed to update the treatment plan in client records, #1, 2.

Client #1 was admitted on 11/25/16 and was an active client at the time of the licensing inspection.

A treatment plan update was documented on 2/17/17; a treatment plan update was due by 4/17/17 but was not documented until 5/4/17.

Client #2 was admitted on 12/10/15 and was an active client at the time of the licensing inspection.

Plan of Correction

On November 30, 2017 this author completed a review of 709.92 with the Clinical Management Team. Clinical management team members where instructed to commence a review, with their teams, as to the timely completion of all treatment planning preparation and completion.

A constant and thorough review of the timeliness to treatment plan development and updates, to ensure and correct deficiencies in this area, has been implemented with the reorganization and addition of the newly appointed clinical supervisor and clinical team leaders. This responsibility being shared with these team members will afforded a greater accountability to staff and patient

A treatment plan update was documented on 12/13/16; a treatment plan update was due by 2/13/17 but was not documented until 3/8/17. Additionally, a treatment plan update was documented on 6/9/17; a treatment plan update was due by 8/9/17 but was not documented until 8/28/17.

Client #3 was admitted on 1/24/17 and was an active client at the time of the licensing inspection.

A treatment plan update was documented on 4/10/17; a treatment plan update was due by 6/10/17 but was not documented until 7/24/17. Additionally, a treatment plan update was due by 9/24/17 but was not documented until 10/24/17.

Client #4 was admitted on 9/6/16 and was discharged on 3/29/17.

A treatment plan update was documented on 1/4/17; a treatment plan update was due by 3/4/17 but was not documented at the time of the licensing inspection.

Client #6 was admitted on 12/13/16 and was discharged on 4/11/17.

A comprehensive treatment plan was documented on 1/9/17; a treatment plan update was due by 3/9/17 but was not documented at the time of the licensing inspection.

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

attention. Reviews of such are projected to be completed on a regular basis (Weekly or bi-weekly). A thorough review of this matter will be presented, and discussed, with all clinical team members during the clinical team meeting slated for January 12, 2018 with full implementation expected to commence on January 15, 2018 and forward.

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HABIT OPCO, INC.
118 MONAHAN AVENUE
DUNMORE, PA 18512

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/20/2017

INITIAL COMMENTS

This report is a result of a project-wide policy review conducted on November 20-21, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc. 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

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

After a review of the project's client rights policy, the project failed to include the following elements:(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.These findings were reviewed with facility staff.

Plan of Correction

Dunmore CTC will review its patients' rights policy draft and add edits to include the noted observations under § 709.30 to ensure that all elements are contained within. This revision will be completed, along with a presentation of the same to all staff and patients; the latter via inclusion in the mandatory policy and procedures group and posting within the Center on the Patient bulletin board. Said revisions to policy to be completed by January 1, 2018.

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