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Statement of Deficiency

MEDICATION-ASSISTED TREATMENT - OPIOID TREATMENT PROGRAM
INITIAL LICENSURE SURVEY
FEBRUARY 6-9, 2017

PROGRAM CENSUS: 170
SAMPLE SIZE: 16

Statement of Deficiency

(1) Based on document review and interview, the opioid treatment program failed to ensure that during all hours of operation every opioid treatment program shall have present and on duty at the program at least one of the following actively-licensed health care professionals: Program physician; Physician extender; Registered nurse. Findings include:

(a) Review of the opioid treatment program's application for licensure dated 01/06/17, which was received by West Virginia Department of Health and Human Resources on 01/10/17, revealed on Page 2 of the application the following dates of operation: Sunday 8:00 a.m. to 9:00 a.m.; Monday through Friday 5:00 a.m. to 5:00 p.m.; and
Saturday 6:00 a.m. to 9:00 a.m.

(b) Interview on 02/07/17 at 3:00 p.m. with Staff B, Clinic Director confirmed that the physician hours for Staff I, Physician is Monday, Wednesday and Friday 8:00 a.m. to 12:00 p.m. and the office hours for Staff A, Physician is Tuesday and Thursday 9:00 a.m. to 3:00 p.m.

(c) Review of the employee list revealed that the opioid treatment program does not employee Physician Extenders or Registered Nurses.

(d) The failure of the the opioid treatment program to ensure that a Program Physician, Physician Extender or Registered Nurse is present during all hours of operation does not meet the intent of the regulation that during all hours of operation every opioid treatment program shall have present and on duty at the program at least one of the following actively-licensed health care professionals: program physician; physician extender; or registered nurse.

Statement of Deficiency

69-11-9.2.c
Based on documentation review and interview the opioid treatment program failed to document in the patient's record if the patient has no insurance or has voluntarily and with full knowledge of the financial obligations, requested a claim not be submitted to their insurer or a rejection of prior authorization, rejection of a submitted claim for written denial from a patient's insurer or

West Virginia Medicaid denying coverage for opioid treatment. Regarding direct billing and acceptance of cash payments from a patient occurs, the opioid treatment program shall clearly document in the patient's record the rationale and medical necessity for acceptance into the program. Patients affected four (4) out of sixteen (16) in the sample. Patient identifiers #1, #2, #8 & #9

Findings include:
a. Review of the medical record for patient #1admitted 9/20/2016 revealed no documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

b. Review of the medical record for patient #2 admitted 11/30/2016 revealed no documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

c. Review of the medical record for patient #8 admitted 10/12/2016 revealed no documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

d. Review of the medical record for patient #9 admitted 11/30/2016 revealed no documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

e. Interview with staff G Clinical Supervisor on 2/09/2017 at 2:20 pm. Confirmed that the medical record for patient # 1 did not contain any documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

f. Interview with staff G Clinical Supervisor on 2/09/2017 at 2:20 pm. Confirmed that the medical record for patient # 2 did not contain any documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

g. Interview with staff G Clinical Supervisor on 2/09/2017 at 2:20 pm. Confirmed that the medical record for patient # 8 did not contain any documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

h. Interview with staff G Clinical Supervisor on 2/09/2017 at 2:20 pm. Confirmed that the medical record for patient # 9 did not contain any documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program.

i. Failure of the opioid treatment program to ensure that each patients record contains documented evidence of the patient not having insurance, requesting a claim not be submitted to their insurer, a claim rejection from the insurer, or documentation of acceptance of financial obligations and no rationale/medical necessity for acceptance into the program does not meet the intent of the regulation that, The opioid treatment program shall document in the patient's record any rejection of prior authorization, rejection of a submitted claim for written denial from a patient's insurer or West Virginia Medicaid denying coverage for opioid treatment. The opioid treatment program shall also clearly document in the patient's record if the patient has no insurance or has voluntarily and with full knowledge of the financial obligations, including all treatment costs, requested a claim not be submitted to their insurer or West Virginia Medicaid. When any instance described in this section regarding direct billing and acceptance of cash payments from a patient occurs, the opioid treatment program shall clearly document in the patient's record the rationale and medical necessity for acceptance into the program.

Statement of Deficiency

Based on document review and interview the MAT program failed to maintain confidential individual personnel files for every clinical staff member or volunteer, that shall contain, at a minimum: Documentation relating to performance, supervision, disciplinary actions and termination summaries. Staff affected : two (2) of six (6) in the sample: Staff identifiers: B and F. Findings include:a. Review of the personnel records for staff B and F revealed no documented evidence of performance evaluations.b. Interview on 2/9/17 at 2:02 p.m with staff G confirmed that no performance evaluations had been done on staff B and F.c Failure of the MAT program to perform evaluations on all employes and maintain the results of such evaluations in the personnel files does not meet the intent of the regulation that each MAT program shall maintain confidential individual personnel files for every clinical staff member or

volunteer, that shall contain, at a minimum: Documentation relating to performance, supervision, disciplinary actions and termination summaries.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that all patient records shall contain identifying and basic demographic data and the results of the screening process. Patients affected: two (2) of sixteen (16) patients in the sample. Patient identifiers: #2 and #9. Findings include:

(a) Review of the medical record for Patient #2 admitted 11/30/16 revealed no documented evidence of identifying data and the results of the screening process.

(b) Review of the medical record for Patient #9 admitted 11/30/16 revealed no documented evidence of identifying data and the results of the screening process.

(c) Interview on 02/09/17 at 2:30 p.m. with Staff G, Clinical Supervisor confirmed that the medical records for Patient #2 and #9 did not contain identifying data and the results of the screening process.

(d) The failure of the Program to ensure that each patient's medical record contains identifying data and the results of the screening process does not meet the intent of the regulation that individual patient records shall contain identifying and basic demographic data and the results of the screening process.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that all patient records contain evidence that the MAT program made a good faith effort to review whether the patient is enrolled in any other MAT program. Patients affected: one (1) of sixteen (16) patients in the sample. Patient identifier: #10. Findings include:

(a) Review of the medical record for Patient #10 admitted 10/03/16 revealed no documented evidence that the MAT program made a good faith effort to review whether the patient is enrolled in any other MAT program.

(b) Interview on 02/09/17 at 2:30 p.m. with Staff H, Nursing Supervisor confirmed that the medical record for Patient #10 had no documented evidence that the MAT program made a good faith effort to review whether the patient is enrolled in any other MAT program and that the form used for this purpose was not filled out in the patient record.

(c) The failure of the Program to ensure that each patient's record contains documented evidence that the MAT program made a good faith effort to review whether the patient is enrolled in any other MAT program does not meet the intent of the regulation that individual

patient records shall contain documentation that the MAT program made a good faith effort to review whether the patient is enrolled in any other MAT program.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that the physicians accessed the database at the patient's intake. Patients affected: one (1) of sixteen (16) patients in the sample. Patient identifier: #10. Findings include:

(a) Review of the medical record for Patient #10 admitted on 10/03/16 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database at the patient's intake.

(b) Interview on 2/08/17 at 2:30 p.m. with Staff H, Nursing Supervisor confirmed that the medical record for Patient #10 had no documented evidence that the physician had accessed the database at the patient's intake.

(c) The failure of the Program to ensure that each patient's record contains documented evidence that the physician had accessed the Controlled Substances Monitoring Program database at the patient's intake does not meet the intent of the regulation that Program physicians shall access the database at the patient's intake.

Statement of Deficiency

69-11-23.2.b

Based on documentation review and interview the clinic failed to insure that the physicians accessed the database before the administration of medication-assisted treatment medications. Patients affected three (3) out of sixteen (16) in the sample. Patient identifiers #2, #4 & #10

Findings include:

a. Review of the medical record for patient #2 admitted on 11/30/2016 revealed no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

b. Review of the medical record for patient #4 admitted on 10/05/2016 revealed no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

c. Review of the medical record for patient #10 admitted on 10/03/2016 revealed no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

d. Interview with Interview with staff H Nursing Supervisor on 2/08/2017 at 2:30 pm confirmed that the medical record for patient #2 had no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

e. Interview with Interview with staff H Nursing Supervisor on 2/08/2017 at 2:30 pm confirmed that the medical record for patient #4 had no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

f. Interview with Interview with staff H Nursing Supervisor on 2/08/2017 at 2:30 pm confirmed that the medical record for patient #10 had no documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications.

g. Failure of the MAT program to ensure that each patients record contains documented evidence that the physician had accessed the database before the administration of medication-assisted treatment medications does not meet the intent of the regulation that, Program physicians shall access the database: before the administration of medication-assisted treatment medications or other treatment in a MAT program.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that the physicians accessed the database after the initial 30 days of treatment. Patients affected: five (5) of sixteen (16) patients in the sample. Patient identifiers: #2, #3, #4, #5 and #10. Findings include:

(a) Review of the medical record for Patient #2 admitted on 11/30/16 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment.

(b) Review of the medical record for Patient #3 admitted on 10/26/16 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment.

(c) Review of the medical record for Patient #4 admitted on 10/05/16 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment.

(d) Review of the medical record for Patient #5 admitted on 01/17/17 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment.

(e) Review of the medical record for Patient #10 admitted on 10/03/16 revealed no documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment.

(f) Interview with on 02/08/17 at 2:30 p.m., Staff H, Nursing Supervisor confirmed that the medical records for Patient #2, #3, #4, #5 and #10 had no documented evidence that the physician had accessed the database after the initial 30 days of treatment.

(g) The failure of the Program to ensure that each patient's record contains documented evidence that the physician had accessed the Controlled Substances Monitoring Program database after the initial 30 days of treatment does not meet the intent of the regulation that Program physicians shall access the database after the initial 30 days of treatment.

Statement of Deficiency

69-11-23.2.d

Based on documentation review and interview the clinic failed to insure that the physicians accessed the database prior to any take home medication being granted. Patients affected two (2) out of sixteen (16) in the sample. Patient identifiers #4 & #10

Findings include:

a.Review of the medical record for patient #4 admitted on 10/05/2016 revealed no documented evidence that the physician had accessed the database prior to any take home medication being granted.

b.Review of the medical record for patient #10 admitted on 10/03/2016 revealed no documented evidence that the physician had accessed the database prior to any take home medication being granted.

c.Interview with Interview with staff H Nursing Supervisor on 2/08/2017 at 2:30 pm confirmed that the medical record for patient #4 had no documented evidence that the physician had accessed the database prior to any take home medication being granted.

d.Interview with Interview with staff H Nursing Supervisor on 2/08/2017 at 2:30 pm confirmed that the medical record for patient #10 had no documented evidence that the physician had accessed the database prior to any take home medication being granted.
e.Failure of the MAT program to ensure that each patients record contains documented evidence that the physician had accessed the database prior to any take home medication being granted does not meet the intent of the regulation that, Program physicians shall access the database: prior to any take home medication being granted, if applicable.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that a physical and biopsychosocial assessment have been completed at least every 90 days. Patients affected: two (2) of sixteen (16) Patients in the sample. Patient identifiers: #1 and #3. Findings include:

(a) Review of the medical record for Patient #1 admitted on 09/20/16 revealed no documented evidence that a physical and biopsychosocial assessment had been completed for the patient after 90 days of treatment.

(b) Review of the medical record for Patient #3 admitted on 10/26/16 revealed no documented evidence that a physical and biopsychosocial assessment had been completed for the patient after 90 days of treatment.

(c) Interview on 02/09/17 at 2:00 p.m. with Staff G, Clinical Supervisor confirmed that the medical record for Patient #1 and #3 had no 90 day physical and biopsychosocial assessment.

(d) The failure of the Program to ensure that each patient's shall have a physical and biopsychosocial assessment at least every 90 days does not meet the intent of the regulation that each patient accepted for treatment at a MAT program shall be assessed including physical and biopsychosocial assessments initially and at least every 90 days following the initial assessment by qualified personnel who shall determine the most appropriate combination of recovery-oriented services and treatment for the patient.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that counseling sessions are provided for all patients at least twice weekly during the first 30 days of treatment. Patients affected: three (3) of sixteen (16) patients in the sample. Patient identifiers: #4, #9 and #10. Findings include:

(a) Review of the medical record for Patient #4 admitted on 10/05/16 revealed no documented evidence that counseling sessions were provided at least twice weekly during the first 30 days of treatment.

(b) Review of the medical record for Patient #9 admitted on 11/30/16 revealed no documented evidence that counseling sessions were provided at least twice weekly during the first 30 days of treatment.

(c) Review of the medical record for Patient #10 admitted on 10/03/16 revealed no documented evidence that counseling sessions were provided at least twice weekly during the first 30 days of treatment.

(d) Interview on 02/09/17 at 2:15 p.m. with Staff G, Clinical Supervisor confirmed that Patient #4, #9 and #10 had not been provided counseling sessions at least twice weekly during the first 30 days of treatment.

(e) The failure of the Program to ensure that each patient shall have counseling sessions at least twice weekly during the first 30 days of treatment does not meet the intent of the regulation that counseling sessions shall be provided according to generally accepted best practices and shall be offered at least twice weekly during the first 30 days of treatment.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that counseling sessions are provided for all patients at least weekly during the next 90 days of treatment. Patients affected: two (2) of sixteen (16) patients in the sample. Patient identifiers: #4 and #10. Findings include:

(a) Review of the medical record for Patient #4 admitted on 10/05/16 revealed no documented evidence that counseling sessions were provided at least weekly during the next 90 days of treatment.

(b) Review of the medical record for Patient #10 admitted on 10/03/16 revealed no documented evidence that counseling sessions were provided at least weekly during the next 90 days of treatment.

(c) Interview on 02/09/17 at 2:15 p.m. with Staff G, Clinical Supervisor confirmed that Patient #4 and #10 had not been provided counseling sessions at least weekly during the next 90 days of treatment.

(d) The failure of the Program to ensure that each patient shall have counseling sessions at least weekly during the next 90 days of treatment does not meet the intent of the regulation that counseling sessions shall be provided according to generally accepted best practices and shall be offered at least weekly during the next 90 days of treatment.

Statement of Deficiency

69-11.29.3Based on documentation review and interview the clinic failed to insure that all patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days and documented in the patient record. Patients affected four (4) out of sixteen (16) in the sample. Patient identifiers #1, #3, #4 & #8Findings include:a. Review of the medical record for patient #1 admitted 9/20/2016 revealed no documented evidence that the patient a patients individualized treatment plan of care shall

be reviewed by the program physician, primary counselor and patient at least every 90 days.b. Review of the medical record for patient #3 admitted 10/26/2016 revealed no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.c. Review of the medical record for patient #4 admitted 10/05/2016 revealed no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.d. Review of the medical record for patient #8 admitted 10/12/2016 revealed no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.e. Interview with staff H Nursing Supervisor confirmed on 2/09/2017 at 2:30 pm confirmed that the medical record for patient #1 had no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.f. Interview with staff H Nursing Supervisor confirmed on 2/09/2017 at 2:30 pm confirmed that the medical record for patient #3 had no documented evidence that the patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.g. Interview with staff H Nursing Supervisor confirmed on 2/09/2017 at 2:30 pm confirmed that the medical record for patient #4 had no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.h. Interview with staff H Nursing Supervisor confirmed on 2/09/2017 at 2:30 pm confirmed that the medical record for patient #8 had no documented evidence that the patient a patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days.i. The failure of the clinic to ensure that each patients individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days does not meet the intent of the regulation that, The individualized treatment plan of care shall be reviewed by the program physician, primary counselor and patient at least every 90 days and documented in the patient record. Reviews shall address each of the objectives identified on the initial plan of care; document all treatment, counseling, medications and other services rendered to the patient; and document the patient's progress. A revised plan of care may be implemented with each review. If a new plan of care is not implemented, the reasons for such decision should be documented in the patient's record. Paper and electronic plans of care, including all reviews and updates, must be acknowledged by the patient.

Thursday, November 12, 2015 - Re-Licensure Survey

Privacy, Security, and Acces

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure that all patients shall sign and date a statement indicating whether he or she wishes to participate in an alternative form of treatment or remain within the program in an ongoing recovery-oriented maintenance format. Patients affected: one (1) of sixteen (16) patients in the sample. Patient identifier: #10. Findings include:

(a) Review of the medical record for Patient #10 admitted 10/03/16 revealed no documented evidence that the patient had a signed and dated statement indicating whether he or she wishes to participate in an alternative form of treatment or remain within the program in an ongoing recovery-oriented maintenance format.

(b) Interview on 02/09/17 at 2:20 p.m. with Staff G, Clinical Supervisor confirmed that the medical record for Patient #10 did not contain any documented evidence that the patient had a signed and dated statement indicating whether he or she wishes to participate in an alternative form of treatment or remain within the program in an ongoing recovery-oriented maintenance format.

(c) The failure of the Program to ensure that each patient's record contains documented evidence that the patient had a signed and dated statement indicating whether he or she wishes to participate in an alternative form of treatment or remain within the program in an ongoing recovery-oriented maintenance format does not meet the intent of the regulation that at the time of the quarterly review, the patient shall again be presented with the option of participating in alternative treatment, such as medically-supervised withdrawal. The patient shall sign and date a statement indicating whether he or she wishes to participate in an alternative form of treatment or remain within the program in an ongoing recovery-oriented maintenance format. The statement shall be included with the patient's individualized treatment plan of care.