Pennsylvania Department of Health

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

HABIT OPCO, INC. - POTTSTOWN

301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/23/2015

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on January 23, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the complaint investigation, the allegations against Habit Opco, Inc Pottstown were unable to be substantiated. 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. - POTTSTOWN
301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

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Survey conducted on 03/12/2015

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on March 12, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint 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. - POTTSTOWN

301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

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Survey conducted on 06/03/2015

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on June 3, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint 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. - POTTSTOWN
301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

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Survey conducted on 09/17/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on September 15, 2015 through September 17, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc. - Pottstown 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 supervisors.

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.

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.

These findings were reviewed with facility staff during the

licensing process.

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

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

Observations

Based on a review of the facility's Staffing Requirements Facility Summary Report (SRFSR) and a review of the personnel training files, the facility failed to ensure that all personnel received a minimum of 6 hours of HIV/AIDS training using a Department approved curriculum within the regulatory time frames.

Plan of Correction

Employee #5 completed the HIV/AIDS training on September 25, 2015. Certificate of attendance has been placed in the HR file accordingly. All newly hired staff will complete the required trainings with the first year of hire, as required by the State regulations. Clinic Director will monitor accordingly.

The findings include:

The SRFSR form completed by the facility and a review of personnel training files were reviewed on September 15, 2015. The facility failed to provide HIV/AIDS training for one of eighteen staff employed, specifically employee #5.

Employee #5 was hired as a counselor on July 21, 2014. HIV/AIDS training was due to be completed no later than July 21, 2015. However, there was no documentation of HIV/AIDS training on the SRFSR, as well as in the employee's training file.

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

705.22 (1) LICENSURE Building exterior and grounds.

705.22. Building exterior and grounds. The nonresidential facility shall: (1) Maintain all structures, fences and playground equipment, when applicable, on the grounds of the facility so as to be free from any danger to health and safety.

Observations

Based on observation during the physical plant inspection, the facility failed to keep the grounds of the facility free from any danger to health and safety of the clients and staff.

Plan of Correction

Pottstown Glass Co. is scheduled to replace the window today (10/9/15.) Any future repeat incidents will be managed immediately by the Clinic Director to ensure the safety of patients and staff, as opposed to waiting for the landlord to respond.

The findings include:

A physical plant inspection was conducted on September 17, 2015. It was during the inspection, it was observed that a pane of glass, roughly the size of 3 1/2 feet X 3 1/2 feet, was broken. Half of the glass was gone; however, the other half was still attached with sharp edges of broken glass being exposed. Therefore, there is the possibility of a patient or staffmember to be severely cut or injured.

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

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

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

Observations

Based on a review of client records, the facility failed to either document an annual evaluation of the patient or failed to have the medical director sign and date the evaluation in three of nine client records reviewed.

Plan of Correction

Beginning 10/9/15, Clinical Supervisor will monitor Annual Evaluations due on a weekly basis in supervision with staff. Weekly review of evaluations will be completed by the CS and signatures will be verified. Clinic Director will monitor signature of Clinical Supervisor and MD in the EMR ongoing.

The findings include:

Seventeen client records were reviewed on September 15, 2015 through September 17, 2015. Nine client records required documentation of an annual evaluation signed and dated by the counselor and the medical director. The facility failed to have the counselor or medical director sign and date the annual evaluation in client records, #1 and 2. Additionally, the facility failed to document an annual evaluation in client record #10.

Client #1 was admitted into treatment on September 9, 2014 and was still an active client as of the date of the on-site inspection. There was an annual evaluation completed on 09/14/2015; however, the evaluation was not signed and dated by the medical director as of the date of the inspection.

Client #2 was admitted into treatment on April 17, 2014 and was still an active client as of the date of the on-site inspection. There was an annual evaluation completed on 09/09/2015; however, the evaluation was not signed and dated by the primary counselor and the medical director as of the date of the inspection.

Client #10 was admitted into treatment on July 15, 2014 and was still an active client as of the date of the on-site inspection. An annual evaluation was due to be completed by 07/15/2015; however, there was no documentation of an annual evaluation in the client record as of the date of the inspection.

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

715.23(d)(2) LICENSURE Patient records

(d) A narcotic treatment program shall prepare a treatment plan that outlines realistic short and long-term treatment goals which are mutually acceptable to the patient and the narcotic treatment program. (2) The narcotic treatment physician or the patient 's counselor shall review, reevaluate, modify and update each patient 's treatment plan as required by Chapters 157, 709 and 711 (relating to drug and alcohol services general provisions; standards for licensure of freestanding treatment activities; and standards for certification of treatment activities which are a part of a health care facility).

Observations

Based on a review of client records, the facility failed to document treatment plan updates within the 60-day regulatory period as required by Chapter 709 in four of seventeen client records reviewed.

The findings include:

Seventeen client records requiring documentation of treatment plan updates within the regulatory timeframe were reviewed on September 15, 2015 through September 17, 2015. The facility failed to document 60-day treatment plan updates in client record #'s preliminary treatment and rehabilitation plans in client records #4, 5, 6, and 10.

Client #4 was admitted into treatment on November 24, 2014 and was still an active client as of the date of the on-site inspection. A treatment plan update was completed on 04/27/2015 and the next treatment plan was completed on 07/27/2015, which was outside of the 60-day timeframe required in Chapter 709.

Client #5 was admitted into treatment on March 09, 2015 and was still an active client as of the date of the on-site inspection. A treatment plan update was completed on 06/26/2015 and the next treatment plan was to be completed by 08/26/2015. However, the treatment plan was not completed until 09/03/2015.

Client #6 was admitted into treatment on December 16, 2014 and was still an active client as of the date of the on-site inspection. A treatment plan update was completed on 05/27/2015 and the next treatment plan was completed on 07/04/2015, which was outside of the 60-day timeframe required in Chapter 709. Additionally, a treatment plan update was due to be completed by 09/03/2015; however, there was no update completed at the time of the inspection.

Client #10 was admitted into treatment on July 15, 2014 and was discharged February 12, 2015. The comprehensive treatment plan was completed on 07/21/2014 and an update was due to be completed by 09/21/2014. However, the treatment plan update was not documented in the client chart until 10/15/2014.

Plan of Correction

Beginning 10/9/15, all treatment plan updates due will be reviewed weekly by the Clinical Supervisor with respective staff. Timeliness of documentation will be monitored and addressed in supervision weekly as well. Clinical Supervisor will generate weekly reports via the EMR system to monitor and address issues accordingly.

Of the client records reviewed and noted, client #6 received a treatment plan update on 9/18/15. Subsequent plan is scheduled for 11/16/15.

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

709.91(b)(4) LICENSURE Intake and admission

709.91. Intake and admission. (b) Intake procedures shall include documentation of: (4) Consent to treatment.

Observations

Based on a review of client records, the facility failed to provide documentation of a consent to treatment form as part of their intake procedures in two of two client records reviewed.

The findings include:

Two client records requiring client signed consent to treatment forms were reviewed on September 15, 2015 through September 17, 2015. There was no documentation of consent to treat forms in client records, #8 and 18.

Client #8 was admitted into treatment on August 18, 2015 and was still an active client at the time of the inspection. There was no documentation of a signed and dated consent to treatment form in the client record as of the date of the inspection.

Client #18 was admitted into treatment on June 24, 2015 and was discharged on September 14, 2015. There was no documentation of a signed and dated consent to treatment form in the client record as of the date of the inspection.

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

Plan of Correction

Beginning 10/9/15, Consent to treat form will be signed upon intake for both MMTP and Drug-Free patients. This is inclusive of signing a consent to treat when transferring from MMTP to Drug Free Outpatient services.

Of the patient records reviewed, #8 and #18 have both been discharged, one of which was an active patient at the time of the inspection. We have since obtained an Informed Consent document to utilize for all Drug-Free admissions moving forward.

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HABIT OPCO, INC. - POTTSTOWN

301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 08/08/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on August 08, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the investigation, the allegations against Habit OPCO, Inc. (Pottstown) were unsubstantiated. Therefore, the facility were found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

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HABIT OPCO, INC. - POTTSTOWN
301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/26/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on October 24, 2016 thru October 26, 2016 by staff from the Department of Drug and Alcohol Programs, Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. Based on the findings of the on-site inspection, Habit OPCO, Inc. - Pottstown 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

704.5(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 24, 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.

705.24 (3) LICENSURE Bathrooms.

705.24. Bathrooms. The nonresidential facility shall: (3) Have hot and cold water under pressure. Hot water temperature may not exceed 120F.

Observations

Based on a physical plant inspection on October 26, 2016 at 1:30 pm, the hot water temperature in the staff bathroom close to the lobby was measured at 128.5 degrees and the water temperature in the client bathroom close to the lobby was measured at 129.0 degrees.

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

Plan of Correction

In review of this issue, it was determined that there are two thermostats on the hot water heater. Once the second thermostat was adjusted, the temperature adjusted accordingly and this issue was resolved.

705.28 (d) (4) LICENSURE Fire safety.

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

Observations

A review of the October 2015 through September 2016 fire drill logs was conducted during the onsite inspection. The fire drill logs for the months of October 2015, February 2016, May 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. The logs for all months, except February 2016 and September 2016, failed to include the exit route used. Additionally, the logs for November 2015, January 2016, March 2016, April 2016, June 2016, August 2016, and September 2016 did not state whether a fire alarm or smoke detector was operative at the time of the drill.

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

Plan of Correction

Beginning with the monthly fire drill in November, 2016, a revised form will be utilized and will reflect the following additional information:

Exit route

Number of persons evacuated

Fire alarm/smoke detector operative

All information, inclusive of the time of each drill, will be recorded by the and reviewed monthly by the Office Manager, as well as during quarterly Safety Committee meetings.

Unannounced monthly fire drills will be conducted by Administrative staff and monitored by the Office Manager via monthly report. Reports will also be reviewed by the Director on a quarterly basis.

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.

Observations

Based on the review of patient records, the facility failed to

Plan of Correction

All active patients will have signed consent forms for their

document an informed and voluntary consent to release information form prior to the disclosure of information in patient records, #1, 2,3,4,5,6,7,8,10 and 11.

Patient #1 was admitted on December 9, 2013 and was discharged on March 17,2016. The record did not contain a consent for the funding source, despite evidence that billing was submitted.

Patient #2 was admitted on December 15, 2015 and was discharged March 16,2015. The record did not contain consent for the funding source, despite evidence that billing was submitted.

Patient #3 was admitted on October 28, 2015 and was discharged February 1,2016. The record did not contain consent for the funding source, despite evidence that billing was submitted

Patient #4 was admitted on July 7, 2016 and was active at time of inspection. The record did not contain a current consent for the funding source, despite evidence that billing was submitted

Patient #5 was admitted on July 23, 2012 and was active at time of inspection. A consent to release form was signed and dated on 07/7/16 to the funding source that allowed for the release of "requested information for insurance," which exceeds what is allowed by 4 PA Code 255.5.

Patient #6 was admitted on May 31, 2016 and was active at the time of inspection. The consent form for the funding source was signed 8/12/2016 and only allowed for the release of patients diagnosis, despite evidence that more information for billing was submitted.

Patient #7 was admitted on December 29, 2015 and was discharged on October 11, 2016. The record did not contain a consent for the funding source, despite evidence that billing was submitted.

Patient #8 was admitted on July 7, 2014 and was discharged on December 16, 2015. The record contain a consent for the funding source, despite evidence that billing was submitted.

Patient #10 was admitted on March 21, 2016 and was active at time of inspection. The record did not contain a current consent for the funding source, despite evidence that billing was submitted.

respective funding source by December 15, 2016 in the EMR. The Office Manager and the Clinical Supervisor will complete all ROIs for all active patients and patients will be prompted to sign thereafter. Moving forward, the Counselors will set up the initial releases for the funding sources during the time of intake to ensure completion during the admission process.

All clinicians will have an additional training regarding confidentiality documented by 11/30/16, inclusive of review of proper disclosures. The Clinical Supervisor will facilitate the training and the Office Manager will ensure training evals are completed for the HR files.

Patient #11 was admitted on August 11, 2014 and was active at time of inspection. The record did not contain a consent for the funding source, despite evidence that billing was submitted.

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

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 May, June, 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 11 weeks of the 24 weeks reviewed.

During the week of May 1-7, 2016, the patient census was 273. The facility was required to provide at least 27.3 physician hours. There were 25 physician hours documented.

During the week of May 8-14, 2016, the patient census was 271. The facility was required to provide at least 27.1 physician hours. There were 25 physician hours documented.

During the week of May 15-21, 2016, the patient census was 269. The facility was required to provide at least 26.9 physician hours. There were 25 physician hours documented.

During the week of May 22-28, 2016, the patient census was 271. The facility was required to provide at least 27.1 physician hours. There were 25 physician hours documented.

During the week of May 29-June 4, 2016, the patient census was 271. The facility was required to provide at least 27.1 physician hours. There were 20 physician hours documented.

During the week of June 5-11, 2016, the patient census was 274. The facility was required to provide at least 27.4 physician hours. There were 14 physician hours documented.

During the week of June 12-18, 2016, the patient census was 273. The facility was required to provide at least 27.3 physician hours. There were 24.5 physician hours documented.

During the week of June 26-July 2, 2016, the patient census was 272. The facility was required to provide at least 27.2 physician hours. There were 20 physician hours documented.

During the week of July 3-9, 2016, the patient census was 274. The facility was required to provide at least 27.4

Plan of Correction

As of June 2016, the facility added a part-time CRNP to the team. As evidenced by physician timesheets in recent months, all required physician hours are now met in accordance with the 1:10 ratio on a weekly basis. In addition, the CRNP has been hired FT, effective 1/1/17, to further ensure this requirement is met in both Allentown and Pottstown facilities.

physician hours. There were 18 physician hours documented.

During the week of August 27- September 3, 2016, the patient census was 271. The facility was required to provide at least 27.1 physician hours. There were 20.5 physician hours documented.

During the week of September 4-10, 2016, the patient census was 273. The facility was required to provide at least 27.3 physician hours. There were 25 physician hours documented.

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

715.20(3) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (3) The transferring narcotic treatment program shall document what materials were sent to the receiving narcotic treatment program.

Observations

Based on review of patient records, patient #2's record did not contain documentation that the facility sent the required patient information, which is to include admission date, medical and psychosocial summaries, dosage level, urinalysis results, exception requests, and current status of patient, to the receiving narcotic treatment program. Patient #2 was admitted on December 15, 2015 and was transferred to another treatment facility on March 15, 2016.

Plan of Correction

Beginning 12/1/16, the required patient information to be sent to a receiving narcotic treatment program will be documented via a checklist and signed by the sending Counselor. This checklist will include admission date, medical and psychosocial summaries, dosage level, urinalysis results, exception requests, and current status of patient.

The findings were discussed 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 patient records, patient records #5, 8, 10 and 11 had treatment plan updates completed after the regulatory timeframe or missing at the time of the inspection.

Plan of Correction

Beginning 10/28/16, all treatment plan updates due will be reviewed weekly by the Clinical Supervisor with respective staff. Timeliness of documentation will be monitored and addressed in supervision weekly as well. Clinical Supervisor will generate weekly reports via the EMR system to monitor and address issues accordingly.

Patient #5 was admitted on July 23, 2012 and was an active patient at time of inspection. A treatment plan update was completed March 23, 2016 and the next update was due no later than May 23, 2016. However, the next update was not completed until June 22, 2016.

Patient #8 was admitted on July 7, 2014 and was administratively discharged on December 16, 2016. A treatment plan update was completed September 13, 2016 and the next update was due no later than November 13, 2016. However, the next update was not completed until December 14, 2016.

Patient #10 was admitted on March 21, 2016 and was an active patient at time of inspection. A treatment plan update was completed on April 25, 2016 and the next update was due no later than June 25, 2016; however, the next documented update was not completed until July 7, 2016.

Patient #11 was admitted on August 11, 2014 and was an active patient at time of inspection. A treatment plan update was completed on March 14, 2016 and the next update was due no later than May 14, 2016; however, the next documented update was not completed until June 13, 2016. The next update was due no later than August 13, 2016; however, the next documented update was not completed until August 30, 2016.

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

709.94(g) LICENSURE Project management services

709.94. Project management services. (g) Outpatient projects which receive reimbursement under the medical assistance program shall have a current, signed provider agreement with the Department of Public Welfare and comply with 55 Pa. Code Part III (relating to Medical Assistance Manual).

Observations

Based on a review of patient records, patient #'s 1, 6, 7, and 8 were identified as medical assistance clients and the facility failed to document the physician signature on the patient's treatment plan updates.

Patient #1 was admitted on December 9, 2013 and was discharged on March 17, 2016. The facility failed to document the physician signature on the patient's updated treatment plans, dated 3/9/2016 and 9/14/2015.

Patient #6 was admitted on May 31, 2016 and was active at time of inspection. The facility failed to document the physician signature on the patient's updated treatment plans, dated 8/31/2016 and 9/30/2016.

Patient #7 was admitted on December 29, 2015 and was discharged on October 11, 2016. The facility failed to document the physician signature on the patient's updated treatment plan, dated 3/22/2016.

Patient #8 was admitted on July 7, 2014 and was discharged on December 16, 2015. The facility failed to document the physician signature on the patient's updated treatment plan, dated 12/14/16.

Plan of Correction

As current practice, the MD reviews all tx plan updates weekly. Beginning the week of 11/21/16, the MD will review updates 2x/week, schedule permitting, to ensure all are reviewed and signed accordingly.

MD will review and sign the treatment plan updates for client #6 by 11/30/16.

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

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HABIT OPCO, INC. - POTTSTOWN

301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/18/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on November 09, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, Habit OPCO-Pottstown 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. - POTTSTOWN

301 CIRCLE OF PROGRESS DRIVE
POTTSTOWN, PA 19464

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Survey conducted on 08/03/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on August 3, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, Habit OPCO, Inc.-Pottstown 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. - POTTSTOWN
301 CIRCLE OF PROGRESS DRIVE
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Survey conducted on 11/21/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection 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.-Pottstown, 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

704.9(a) LICENSURE Counselor Asst Supervision

704.9. Supervision of counselor assistant. (a) Supervision. A counselor assistant shall be supervised by a full-time clinical supervisor or counselor who meets the qualifications in 704.6 or 704.7 (relating to qualifications for the position of clinical supervisor; and qualifications for the position of counselor).

Observations
Employee #8 was hired as bachelor's level counselor assistant on 4/17/17. A supervision log, which contains a column to denote when direct observation occurs, indicated that supervision was provided on a weekly basis from 5/2/17 through 11/20/17, however 1 hour of direct observation was only documented during the following weeks: 5/22-26/17, 6/5-9/17, 7/10-14/17, 7/17/21/17, 7/24/28/17, 8/7/-11/17, 8/21-25/17, 8/28-9/1/17, 9/4-8/17, 9/18-22/17 and 9/25-29/17. #8 was out on medical leave from 9/29/17 through 11/20/17, therefore no supervision was conducted during that timeframe. This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction
Current Counselor Assistant was promoted to Counselor as of 11/27/17, thus negating the need for continued direct observation. Clinical Supervisor will provide ongoing supervision as scheduled. Should a Counselor Assistant be hired in the future,supervision will be conducted by the Clinical Supervisor in accordance with the educational level of said CA. All supervision will be documented accordingly by the Clinical Supervisor. This will be monitored monthly by the Facility Director.

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 20, 2017, the facility failed to ensure that employees #3, 6 & 9 did not exceed 35 active clients.Employee #3 works 22.5 hours and has 31 clients yielding a ratio of 49:1.Employee #6 works 37.5 hours and has 43 clients yielding a ratio of 42:1.Employee #9 works 34.5 hours and has 35 clients yielding a ratio of 36:1. This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction
As of 12/14/17, Facility Director is currently in the process of recruiting and hiring staff to correct the issue of ratio compliance. Staff returning from FMLA on 1/2/18, which will further enable the maintenance of ratio compliance. The Clinical Supervisor will monitor ratio weekly, when assigning new admissions to counselors.

709.30 (1) LICENSURE Client rights

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

Observations

Facility policy and procedure manual was reviewed on November 20, 2017. The facility policy failed to include the following elements with regard to client rights:(3) Clients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record. (4) Clients have the right to appeal a decision limiting access to their records to the director. (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records. (6) Clients have the right to submit rebuttal data or memoranda to their own records.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

As of 12/4/17, the Project policy regarding Client Rights, and related documents, was revised to include the following:

To inspect their own records, in the presence of the CTC Director/designee. 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.

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

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

c. Clients have the right to submit rebuttal data or memoranda to their own records.

The policy and procedure manual for the facility has been updated accordingly.

In addition, the client rights form has been updated. All patients will have the revised client rights form presented and signed by 1/31/18. This will be reviewed by the Facility Director to ensure completion at that time.

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 administraive paperwork and a review of the physician's schedule on November 20, 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 June 5, 2017 through October 10, 2017. The facility was not in compliance for the following weeks:June 5-11, 2017: census 266, requiring 26.6 hours. Actual coverage: 24 hours.June 12-18, 2017: census 267, requiring 26.7 hours. Actual coverage: 24 hours.This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

As of 12/5/17, the Facility Director and Assistant Director will monitor census weekly via EMR reports to ensure doctor hours are sufficient for the current number of patients. Coverage will be provided for when the physician and the physician extender is unable to fulfill their contracted hours in a given week.

715.23(b)(5) LICENSURE Patient records

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

Observations

Seven client records were reviewed on November 21, 2017, four of which were methadone client records. The facility failed to conduct an annual physical annually in client records #3 & 4.Client #3 was admitted on 7/10/14 and was an active client at the time of the licensing inspection. An

Plan of Correction

As of 12/5/17, the Nurse Manager will place a scheduling hold for each patient due for an annual physical, two weeks prior to the due date. Appointments will be scheduled by the nurses. The MD/CRNP will document any "no show" appointments accordingly and notify nursing to indicate the

annual physical examination was conducted on 7/24/16; another annual physical was due to be conducted by 7/24/17 but was not documented until 9/18/17.Client #4 was admitted on 12/8/15 and was discharged on 2/10/17. An initial physical examination was conducted on 12/8/15; an annual physical was due to be conducted by 12/8/16 but was not documented until 1/8/17.This information was reviewed with the facility staff during the licensing inspection.

need for a reschedule. The Nurse Manager will monitor all Annual Physical appointments weekly.

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 21, 2017, four of which were methadone client records; the facility failed to update the treatment plan in client records, #1 and 3.Client #1 was admitted on 7/17/15 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 5/22/17; a treatment plan update was due by 7/22/17, but was not documented until 9/13/17.Client #3 was admitted on 7/10/14 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 5/17/17; a treatment plan update was due by 7/17/17, but was not documented until 8/16/17. Additionally, a treatment plan update was documented on 9/15/17; a treatment plan update was due by 11/15/17, but was not documented until 11/17/17.This information was reviewed with the facility staff during the licensing inspection.

Plan of Correction

As of 12/5/17, all Counselors will print the services due report weekly. Treatment plan updates will be completed every 60 days and monitored via this report. Appointments to review updated treatment plan goals/objectives or to complete a treatment plan with the patient will be scheduled accordingly by Counselors. Appointments not kept by patients will be documented in the EMR under "no show treatment plan appointment." Services due reports will be reviewed in supervision with the Clinical Supervisor to ensure timeliness of documentation.

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