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.
759 SUSQUEHANNA TRAIL
WATSONTOWN, PA 17777

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/24/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection, conducted on March 23 - 24, 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

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

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

Observations

Based on a review of the Staffing Requirements Facility Summary Report form, the facility failed to ensure all staff persons receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of TB/STD training. The findings include:The Staffing Requirements Facility Summary Report form was completed by the facility on February 20, 2015. The facility failed to ensure all staff persons received a minimum of 6 hours of HIV/AIDS and at least 4 hours of TB/STD training. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment. Employee # 4 a counselor was hired July 29, 2013. HIV/AIDS training and TB/STD training was to be completed within the first year of employment or by July 29, 2014. The facility failed to ensure employee # 4 completed the required training's at the time of inspection on March 24, 2015. Employee # 5, the security guard was hired August 27, 2012. HIV/AIDS training and TB/STD training was to be completed within the first 2 years of employment or by August 27, 2014. The facility failed to ensure employee # 5 completed the required training's at the time of inspection on March 24, 2015. The findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Mandatory Communicable Disease Training was scheduled and completed by all identified staff members on Monday April 13, 2015. Certificates of completion have been documented in the staff members personnel records. Future recurrence of this deficiency will be prevented via assessment of staff training at the time of annual staff training plan development. The assessment will be completed by the Admin Assistant and will be reviewed by the Clinic Director during Q4 of each calendar year.

705.28 (d) (1) LICENSURE Fire safety.

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

Observations

Based on a review of the facility's fire drill log, the facility

Plan of Correction

Fire Drills will be expanded to include various times and the

failed to alternate exit routes and conduct fire drills on different staffing shifts. The findings include:On March 24, 2015, the facility's fire drill log was reviewed covering the period of March 2014 through February 2015. The facility failed to prepare alternate exit routes and conduct fire drills on different staffing shifts. The facility documented 'front exit' during each monthly fire drill. In addition, the fire drills were only done on Saturday and Sunday during the 7 AM and 8 AM hour. The findings were reviewed with facility staff during the licensing process.

use of alternate egresses of which the facility has two (2). This process will be reviewed during the May 8, 2015 Monthly Staff meeting to ensure effective communication and implementation to the same.Quarterly reviews will be conducted by the Clinic Director to ensure compliance with this standard.

709.22(e) LICENSURE Governing Body

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

Observations

Based on a review of administrative documentation, the governing body failed to make an annual report available to the public.The findings include:The facility's administrative documentation was reviewed on March 24, 2015. The governing body failed to provide the annual report for the 2013/2014 fiscal year during the pre-submission process which was due February 20, 2014 or during the annual inspection which was conducted March 23 - 24, 2015. The findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Program Director will ensure that an annual report prepared for PA licensing standards will be offered for review and made available for public viewing. Notice that the plan is available for viewing will be filed as a legal notice in the Bar Association or Newspaper of the companies choice within 3 months of the publication of this report. Proof of publication will be provided annually upon reinspection. This will be reviewed by the Clinic Director annually.

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

Based on a review of administrative documentation, the facility failed to file a written Unusual Incident Report with the Department within 48 hours following an unusual incident including the complaints of patient abuse (physical, verbal, sexual and emotional).The findings include:The facility's administrative documentation, including unusual incident reports was reviewed on March 24, 2015. The facility failed to file a complaint of patient abuse to the Department within 48 hours. The findings were reviewed with facility staff during the methadone monitoring process.

Plan of Correction

The Program Director, or their designee, will ensure that a Unusual Incident Report is filed with the Department in 48 hours if/when an event involving reports of: Abuse, Death or Serious injury, significant operational disruption, negative community impact or drug related hospitalization of a patient present themselves. This regulation will also be reviewed during the May 8, 2015 staff meeting to ensure any and all data is accurately captured for the Unusual Incident Report. Internal Incident reports will be reviewed and cross referenced against external reports on a quarterly basis, by the Regional Director, to ensure that this reporting is occurring as identified.

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 which included documentation of case consultations in four of ten and a discharge summary in one of four client records. The findings include:Ten client records were reviewed on March 24, 2015. The facility failed to document a complete client record which included case consultations in four of ten records, and a discharge summary in one of four client records required; client record # 6, 8, 9, and 10.Client # 6 was admitted to the program on January 26, 2013. The facility failed to document a complete client record which included a case consultation in client record # 6. Client # 8 was admitted to

Plan of Correction

The Program Director, or their designee, will ensure that an updated training is completed with all staff regarding the proper and timely completion of documentation required in the Patient chart. This training will occur during the Monthly Staff meeting on May 8, 2015. The auditor's report and findings will be included as examples for this effort.Ongoing comkpliance with the timely documentation will be reviewed via quarterly chart audits of open and closed records by the Regional Director or designee.

the program on November 13, 2014. The facility failed to document a complete client record which included a case consultation in client record # 8. Client # 9 was admitted to the program on November 25, 2014. The facility failed to document a complete client record which included a case consultation in client record # 9.Client # 10 was admitted to the program on July 18, 2014. The facility failed to document a complete client record which included a case consultation and a discharge summary in client record # 10.The findings were reviewed with facility staff during the inspection process

Return to Pennsylvania Department of Health Home Page

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.

759 SUSQUEHANNA TRAIL
WATSONTOWN, PA 17777

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/18/2015

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on November 13, 2015 and a follow-up investigation conducted on November 18, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, the allegations against Habit Opco, Inc. were unable to be substantiated. No areas of noncompliance with the applicable chapters of 28 PA Code which pertain to the facility were identified during this investigation; therefore, no plan of correction is required.

Plan of Correction

Return to Pennsylvania Department of Health Home Page

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.
759 SUSQUEHANNA TRAIL
WATSONTOWN, PA 17777

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 02/12/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on February 11-12, 2016 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

704.11(b)(1) LICENSURE Individual training plan.
704.11. Staff development program. (b) Individual training plan. (1) A written individual training plan for each employee, appropriate to that employee's skill level, shall be developed annually with input from both the employee and the supervisor.

Observations
Based on a review of personnel records, the facility failed to provide documentation of individual training plans in two of six personnel records reviewed.The findings include:Six personnel records requiring documentation of individual training plans were reviewed on February 11, 2016. The facility training year runs from January 1 to December 31. The facility failed to provide documentation of individual training plans for employees #1 and #6.Employee # 1 was hired on November 29, 2011 and the individual training plan was not documented for the 2016 training year. Employee # 6 was hired on December 28, 2015 and the individual training plan was not documented for the 2016 training year. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The program director will ensure that any and all trainings documentations required for on-site inspections, including the Individual Annual Training Plan, are available and/or if they have been modified due to acquisition protocol, that there is some other form of notification/draft from the appropriate level parties; that is viable and available for review/consideration to ensure compliance to 704.11(b)(1).

Additionally the program director will review with onboarding and management team during our monthly staff meeting on Thursday, March 10, 2016, the importance to ensure new hire paperwork, to include Individual training plans, are prepared at the point a new staff member commences their employ; regardless of the point within the training year. As for staff member #6, the said plan was provided on 3/3/2016 upon their return to work, for completion and review with their supervisor. It will be filed accordingly within their personnel record and ready for review in compliance to policy 704.11(b)(1).

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

Observations
Based on a review of personnel records, the facility failed to document the completion of 12 clock hours of annual training

Plan of Correction
The program director will ensure that any and all trainings documentations required for on-site inspections are available

required for the project director. The findings include:The personnel record of the project director requiring the documentation of the completion of 12 clock hours of annual training was not provided at the time of inspection on February 11, 2016. Employee # 1 was hired on November 29, 2011 as project director. The training year for January 1, 2015 to December 31, 2015 was reviewed. The facility failed to provide documentation of the completion of 12 clock hours of annual training for employee #1.These findings were reviewed with facility staff during the licensing process.

and/or if they have been modified due to acquisition protocol, that there is some other form of notification/draft from appropriate level parties that is viable and available for review/consideration to ensure compliance to 704.11(d)(2).

The Program director will inquire as to the re-acquisition of completed trainings misplaced via acquisisiton(s) and ensure that they may be replaced into the Project director's personnel file in additon to any further trainings comleted during 2016.

705.28 (c) (4) LICENSURE Fire safety.

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

Observations

Based on a review of personnel records, the facility failed to document the instruction of staff in the use of the fire extinguisher within seven days of staff employment, in one of six personnel records.The findings include:Six personnel records were reviewed on February 11, 2016. The facility failed to document the completion of fire extinguisher training within seven days of staff employment in personnel record #6. Employee # 6 was hired on December 28, 2015. The training was due within seven days, by January 4, 2016. These findings were reviewed with facility staff during the licensing process

Plan of Correction

The program director will review with on-boarding and management team, during regular monthly staff meetings, commencing with Thursday, March 10, 2016, the importance to ensure new hire paperwork, to include Fire Extinguisher training and instruction, are prepared at the point a new staff member commences their employ; regardless of the point within the training year.

As for staff member #6, Fire Extinguisher training was provided to them on March 3, 2016 upon their return to work. Their successful completion to this training and subsequent graded quiz has since been reviewed by thier supervisor, signed and filed in their personnel file, in compliance to policy 705.28(c)(4).

The onsite Admin. Asst. will ensure that all such training and appropriate documentation to the same are completed and filed accordingly in personnel files for all new hires. The Center Director, will enusure compliance of this staff members execution of this duty on a bi-annual or as needed basis.

As noted, herein, at the time of this draft, staff member #6's training is completed, recorded and has been added to their personnel file.

705.28 (d) (3) LICENSURE Fire safety.

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

Observations

Based on a review of personnel records, the facility failed to ensure that all personnel on all shifts were trained to perform assigned tasks during emergencies, in one of six personnel records reviewed.The findings include:Six records requiring documentation that personnel on all shifts were trained to perform assigned tasks during emergencies, were reviewed on February 11, 2016.Employee # 6 was hired on December 28, 2015. There was no documentation of training for assigned tasks during emergencies in the personnel record.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Program Director will ensure to express to all hiring managers and on-boarding personnel during the next Monthly staff meeting on Thursday, March 10, 2016, as well as to all staff, the need to ensure that all personnel are trained as to their duties in the event of an emergency; regardless of whether or not they may be in orientation or not.

The meeting notations/agenda from the March 10, 2016 staff meeting will serve as record to the corrective measure of this deficiency along with enforcing future compliance to policy 705.28(d)(3).

On March 3, 2016, upon Employee #6's return to work, she completed a training as to fire extinguisher locations and use along with a review of Emergency procedures and protocols specific to the Center and each staff members roles, to ensure Pt. and staff safety in the event of an emergency. Completion of this training et al have been filed in Employee #6's personnel file.

The Admin. Asst. will, as is thier job duty, ensure that all such trainings are done timely upon a new hires orientation to ensure this deficiency is not repeated. Reviews to support compliance to regulation P277 will be conducted bi-annual, or as needed, by the Center Director.

709.26(f) LICENSURE Personnel Management

709.26. Personnel management. (f) There shall be written job descriptions for project positions which include, but are not limited to:

Observations

Based on a review of personnel records, the facility failed to document a written job description in one of six personnel records reviewed, as required by regulation.The findings include:Six personnel records were reviewed on February 11, 2016. The facility failed to obtain the required documentation of a job description in personnel record #1.Employee # 1 was hired on November 29, 2011 as Regional Director. There was no personnel record or documentation of a job description provided for employee #1 at the time of the licensing inspection. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The program director will ensure that any and all new hire paperwork and documents, to include signed job descriptions are available for on-site inspections. If, through acquisition or some other staffing pattern adjustment or acquisition, that there is some other form of notification/draft from appropriate level parties that is viable and available for review/consideration to ensure compliance to 709.26(f).

This matter will also be presented to all HR, on-boarding and management personnel during the March 10, 2016 monthly staff meeting.

709.92(a) LICENSURE Treatment and rehabilitation services

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

Observations

Based on the review of client records, the facility failed to a document, timely or complete individual treatment and rehabilitation plans in six of ten records.The findings include:Ten client records were reviewed on February 11-12, 2016. Client #2 was admitted on July 29, 2015 and the treatment and rehabilitation plan was due on August 29, 2016 but was not completed until September 17, 2015. Type and frequency of services was missing from the treatment and rehabilitation plans in the patient record.Client #3 was admitted on December 5, 2014 and the treatment and rehabilitation plan stated "up to 4 I and 4 G per month" for the type and frequency of services.Client #6 was admitted on August 22, 2014 and the treatment and rehabilitation plan stated "up to 4 I and 4 G per month" for the type and frequency of services.Client #7 was admitted on July 22, 2015 and the treatment and rehabilitation plan was due on August 22, 2015 but was not completed until September 8, 2015. Type and frequency of services stated "up to 4 I and 4 G per month."Client #8 was admitted on November 16, 2015 and the treatment and rehabilitation plan was due on December 16, 2015 but was never completed. Client #10 was admitted January 20, 2016 and is still an active client. The treatment and rehabilitation plan stated "up to 4 I and 4

Plan of Correction

Clinical personnel will be provided with a training related to timely Tx plan completion and to accurate type and frequency measures for clinical compliance.

This training will (was) be offered on March 10, 2016 along with further supervisory oversight and review throughout the calendar year to ensure compliance and on-going training to policy 709.92.

Various options will be reviewed, during regular supervision, to assist clinical personnel with Pt. engagement to this process.

Additionally use of the various options available with the Electronic Health Record on site will be explored to ensure continued compliance to the completion of these documents in a more timely fashion in concert with the fully operational

G per month" for the type and frequency of services.These findings were reviewed with facility staff during the licensing process.

EHR on site.

The Center Director will review the compliance of staff to this metric to ensure this deficiency does not reoccur.

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 client records, the facility failed to document a physician signature on the individual treatment and rehabilitation plan for medical assistance clients. The findings included:Ten client records were reviewed on February 11-12, 2016. Client #1 was admitted to outpatient treatment on January 25, 2016. The individual treatment and rehabilitation plan was developed on February 4, 2016, and did not include a physician signature. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A review with medical and nursing personnel will (was) be conducted on Tuesday, March 8, 2016 as to the need to ensure that the signing of individual training plans for all patients served are reviewed and authorized in accordance to 709.94(g).

A review of the process by which staff have effectively engaged in this process will be examined to correct this cited error to ensure compliance in its entirety.

The Center director, or their nursing/medical designee, will provide on-going reviews, in concert with the Regional Medical Director, to ensure this practice is compliant and does not reoccur.

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health
Inspection Results

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HABIT OPCO, INC.
759 SUSQUEHANNA TRAIL
WATSONTOWN, PA 17777

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/26/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 25-26, 2017 by staff from the Division of Drug and Alcohol Program Licensure, for the approval to use Methadone and Buprenorphine in the treatment of narcotic addiction. Based on the findings of the on-site inspection, 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

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
The facility's fire drill records were reviewed on April 26, 2017 for the period of March 2016 - February 2017. For each month within the reviewed timeframe, the facility failed to maintain a written fire drill record that included the exit route used and the number of persons in the facility at the time of the drill. This finding was reviewed with facility staff during the licensing inspection.

Plan of Correction
As of March 2017, an updated form for fire drills was implemented that includes exit route and number of persons in facility at the time of the drill.

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
Eleven client records were reviewed on April 25-26, 2017. The facility failed to obtain an informed and voluntary consent where consent was applicable for client record # 4. Client # 4 was admitted into methadone maintenance treatment on 8/22/14 and was transferred to another narcotic treatment program on 4/13/17. The client's record contained a consent to release for the receiving narcotic treatment program. This consent form, signed and dated on 9/15/16, allowed for the release of the following information: treatment status verification, prognosis of patient, nature of project, progress of patient, and relapse information, including frequency. Documentation in the client's record indicated that on 4/4/17, the facility sent the following materials to the receiving narcotic treatment program: diagnostic/interpretive summary, dosing history, and past 6 months of urinalysis drug-screen results. The consent to release to the receiving narcotic treatment program did not allow for the release of this information. This finding was

Plan of Correction
Clinic Director reviewed policy and procedure for consent to release information with all staff on 05/04/17. Staff were instructed to include all portions of the ROI will be completed in the EMR including items to be released and the reason. Clinic Director will review all consents to release for transfer prior to releasing any information to ensure that the consent captures all necessary items that are released. Clinic Director also completes 7 random file reviews and will ensure that consent include all information released and take the necessary corrective action if the consents are found to be insufficient for the information released.

reviewed with facility staff during the licensing inspection.

709.33 (a) LICENSURE Notification of termination.

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

Observations

Eleven client records were reviewed on April 25-26, 2017. The facility failed to document that written notification of involuntary termination from treatment was provided to the client for client record # 6. Client # 6 was admitted on 4/27/15 for methadone maintenance treatment and was involuntarily terminated from the facility on 1/6/17. The client's record did not contain documentation that the client was provided written notification of the facility's decision to involuntarily terminate the client's treatment. This finding was reviewed with facility staff during the licensing inspection.

Plan of Correction

Clinic Director has reviewed the involuntary termination policy and procedure with all staff on 05/04/17 to ensure that all documents are completed as required in state regulations and company policy.

715.6(d) LICENSURE Physician Staffing

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

Observations

An onsite licensing inspection was conducted on April 25-26, 2017. Based on the review of administrative documentation, the facility failed to continuously provide narcotic treatment physician services at least one hour per week onsite for every ten clients. During the licensing process, weekly physician time sheets were reviewed for the time period of 1/1/17 - 3/25/17. Based on weekly census data for the methadone maintenance activity, insufficient onsite physician hours were provided for the following weeks: 1 - 7, 20178 - 14, 201715 - 21, 201722 - 28, 201729 - February 4, 20175 - 11, 201712 - 18, 20175 - 11, 201712 - 18, 201719 - 25, 2017This finding was reviewed with facility staff during the licensing process.

Plan of Correction

On 02/27/17, a CRNP was hired and began providing 13 hours a week of onsite services for our patients, while maintaining our physician hours of 8 per week. Our CRNP will provide 2/3 of the required physician time. The Clinic Director will develop and maintain a monthly schedule that denotes days and number of hours each professional will be providing each week ensuring that we meet the 1 hour: 10 patient ratio. The Clinic Director will review and sign off on time sheets weekly for the CRNP and the Physician.

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

An onsite licensing inspection was conducted on April 25-26, 2017. Based on the review of administrative documentation, the facility failed to ensure that one-third of all required narcotic treatment physician time was provided by a narcotic treatment physician. During the licensing process, weekly physician time sheets were reviewed for the time period of 1/1/17 - 3/25/17. Insufficient onsite hours by a narcotic treatment physician were provided for one week out of the time period reviewed. During the week of March 5 - 11, 2017, the patient census was 178. The facility was required to provide at least 17.8 physician hours onsite, of which, 5.9 hours were to be provided by a narcotic treatment physician. For this week, 11 onsite physician hours were provided, all of which were provided by a certified registered nurse practitioner. The facility failed to document the provision of onsite physician hours by a narcotic treatment physician. This finding was reviewed with facility staff during the

Plan of Correction

During the week of March 5-11, no hours were provided on-site by a physician due to illness. As of 05/01/17, Watsontown has developed relationships with two NTP doctors that provide emergency coverage onsite in the event of an unexpected or expected absence. The Clinic Director develops and maintains a monthly schedule for both the CRNP and the physician to ensure that the required number of hours per week are met and will monitor during the course of the month. Clinic Director will review and sign off on timesheets for the Physician and the CRNP each month to ensure that all required time is documented. In the case of an unexpected absence, Clinic Director will contact Addiction Associates to assist in providing the needed coverage. For expected absences, Clinic Director will schedule covering physicians during that time in advance and place them on the monthly schedule.

licensing process.

715.9(a)(4) LICENSURE Intake

(a) Prior to administration of an agent, a narcotic treatment program shall screen each individual to determine eligibility for admission. The narcotic treatment program shall: (4) Have a narcotic treatment physician make a face-to-face determination of whether an individual is currently physiologically dependent upon a narcotic drug and has been physiologically dependent for at least 1 year prior to admission for maintenance treatment. The narcotic treatment physician shall document in the patient 's record the basis for the determination of current dependency and evidence of a 1 year history of addiction.

Observations

Six client records were reviewed for the methadone maintenance activity on April 25-26. The narcotic treatment physician failed to document evidence of a 1 year history of narcotic drug addiction for client records #'s 1 and 2. Client # 1 was admitted into methadone maintenance treatment on 3/28/16 and was still active in treatment. Documentation in the client's record indicated that the physician's documention of addiction was completed on 3/28/16. The physician failed to document evidence of a 1 year history of narcotic drug addiction. Client # 2 was re-admitted into methadone maintenance treatment on 8/26/16 and was discharged on 2/27/17. The client had a prior episode of methadone maintenance treatment at the facility from 4/25/16 - 8/10/16. Documentation in the client's record indicated that the physician's documentation of addiction was first completed on 4/25/16. The physician failed to document evidence of a 1 year history of narcotic drug addiction. Upon the client's readmission to the facility on 8/26/16, a physician's documentation of addiction was completed on 8/26/16. This assessment only documented the client's history of addiction for the time period between treatment episodes. This finding was reviewed with facility staff during the licensing inspection.

Plan of Correction

Clinic Director will review all new intake charts within 7 days of admission to ensure that the physician documents verification of 1 year of opioid dependence at admission.

715.21(2) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (2) A patient terminated involuntarily, except a patient who commits or threatens to commit acts of physical violence, shall be afforded the opportunity to receive detoxification of at least 7 days. The detoxification may take place at the facility or the patient may be referred to another narcotic treatment program or hospital licensed and approved by the Department for detoxification.

Observations

Six client records were reviewed for the methadone maintenance activity on April 25-26, 2017. For client record # 6, the facility failed to document that a client who was involuntarily terminated from treatment was afforded the opportunity to receive at least 7 days of detoxification. Client # 6 was admitted on 4/27/15 for methadone maintenance treatment, and was involuntarily terminated from treatment on 1/6/17, for non-attendance and for failing to follow treatment plan objectives. A medical note documented in the client's record, dated 12/31/16, indicated that the client was being suspended for non-attendance. A follow-up case note, dated 1/5/17, indicated that the client requested to meet with the physician to restart methadone dosing. The same note documents that the client would be informed on the involuntary termination. The client's dosing history log indicated that the client received their final dose of methadone on 12/28/16. The client was absent for dosing on 12/22/16, 12/29/16, and 12/30/16. The dosing history log indicated that dosing for the client was then suspended for the following dates: 12/31/16, 1/1/17, 1/2/17, 1/3/17, 1/4/17, and 1/5/17. A case management note dated for 12/30/16 indicated that facility staff met with the client, and

Plan of Correction

Involuntary termination policy and procedure will be reviewed with the medical team and clinical staff on 06/09/2017 to ensure adherence to state regulations and company policy as it relates to 7 day tapers following involuntary termination.

the client was directed to return for dosing after attending a compliance meeting on that day. A contact note dated for 1/1/17 indicated that the client returned to the facility for dosing on that day, and was informed that they were required to have a face-to-face with the physician prior to being dosed again. The same contact note indicated that the client was given a physician appointment for 1/6/17. An administrative intervention note, dated 1/5/17, indicated that facility staff met with the client. At this time, the client was informed that they were being involuntarily terminated from treatment. Documentation in the client's record failed to indicate that the client was afforded the opportunity to receive at least 7 days of detoxification. This finding was reviewed with facility staff during the licensing inspection.

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health
Inspection Results

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HABIT OPCO, INC.
759 SUSQUEHANNA TRAIL
WATSONTOWN, PA 17777

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 12/13/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on December 12-13, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc.-Watsontown, 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

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.

Plan of Correction

Client Rights policy and procedure will be revised to include the client's rights to appeal a decision limiting access to records to the director; clients having the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records clients have the right to submit rebuttal data or memoranda to their won record. Program Management will review policy and procedure revisions with all staff at the January, 18th 2018 staff meeting.

These findings were reviewed with facility staff during the

licensing process.

715.6(d) LICENSURE Physician Staffing

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

Observations

Based on a review of the physician's schedule conducted on December 12, 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 period from July 31, 2017 through December 1, 2017. The facility was not in compliance for the following weeks:

July 31-August 5, 2017: census 174, coverage 16.5 hours

August 6-12, 2017: census 171, coverage 6 hours

August 13-19, 2017: census 174, coverage 16.5 hours

August 20-26, 2017: census 174, coverage 0 hours

August 27-September 2, 2017: census 176, coverage 10 hours

September 3-9, 2017: census 175, coverage 15 hours

September 10-16, 2017: census 173, coverage 15.5 hours

September 17-23, 2017: census 173, coverage 0 hours

September 24-30, 2017: census 176, coverage 10 hours

October 1-7, 2017: census 176, coverage 9.5 hours

October 8-14, 2017: census 177, coverage 10 hours

October 29-November 4, 2017: census 181, coverage 16 hours

November 5-11, 2017: census 184, coverage 16 hours

November 12-18, 2017: census 182, coverage 16 hours

November 19-25, 2017: census 182, coverage 16 hours

November 26-December 2, 2017: census 184, coverage 16 hours

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

Plan of Correction

Watsontown hired a new NTP Physician that began providing services on 10/16/17 for 16 hours per week. A new CRNP will begin working on 01/09/18 for 8 hours per week. Hours will be tracked by nursing and monitored by the Clinic Director to ensure compliance with this standard.

715.6(e) LICENSURE Physician Staffing

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

Observations

Based on a review of the physician's schedule conducted on

Plan of Correction

With the addition of the CRNP on 01/09/18 at 8 hours a

December 12, 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 period from July 31, 2017 through December 1, 2017. The facility was not in compliance for the following weeks:

August 6-12, 2017: census 171, coverage 6 hours all conducted by CRNP.

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

week, the nursing department will schedule the NTP Physician for 16 hours per week with the CRNP scheduled for 8 hours per week. All changes to this schedule will be approved and monitored by the Clinic Director to ensure compliance with this regulation.

715.17(c)(1)(i-vi)) LICENSURE Medication control

(c) A narcotic treatment program shall develop and implement written policies and procedures regarding the medications used by patients which shall include, at a minimum: (1) Administration of medication. (i) A narcotic treatment physician shall determine the patient 's initial and subsequent dose and schedule. The physician shall communicate the initial and subsequent dose and schedule to the person responsible for the administration of medication. Each medication order and dosage change shall be written and signed by the narcotic treatment physician. (ii) An agent shall be administered or dispensed only by a practitioner licensed under the appropriate Federal and State laws to dispense agents to patients. (iii) Only authorized staff and patients who are receiving medication shall be permitted in the dispensing area. (iv) There shall be only one patient permitted at a dispensing station at any given time. (v) Each patient shall be observed when ingesting the agent. (vi) Administering and dispensing shall be conducted in a manner that protects the patient from disruption or annoyance from other individuals.

Observations

Based on an observation of dosing procedures conducted on December 13, 2017, the facility failed to ensure that a narcotic treatment physician or physician extender submitted a written and signed medication order prior to a dose increase.

A Licensed Practical Nurse conducted a Nursing Assessment on a female patient who was in the induction phase of treatment. Based on a Clinical Opiate Withdrawal Scale and the results of the assessment the LPN increased the patient's dose from 35mg to 40mg.

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

Plan of Correction

Effective 12/13/17, the nurse conducting an assessment with a patient needing or requiring a dosage change will contact the NTP Physician or CRNP to obtain a verbal order prior to any change in dosage level. This procedure was reviewed with the medical department on 12/13/17 by the Clinic Director.

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 December 13, 2017, four of which were methadone client records; the facility failed to provide the required 2.5 hours of therapy per month during the first two years in treatment for one client.

Client #1 was admitted on 1/18/16 and was an active client at the time of the licensing inspection. Client received only 60 minutes of counseling per month from August thru November 2017.

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

Plan of Correction

Clinic Director to address clinical staff at the clinical supervisors meeting on 01/10/18 regarding the one out of seven patients reviewed found to be out of compliance with clinical hours. Clinic Director will review hours with counselors during individual clinical supervision sessions to discuss strategies to engage those individuals missing or avoiding clinical sessions.

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 December 13, 2017, four of which were methadone client records; the facility failed to conduct an annual physical examination on time for clients #1 & 5.

Client #1 was admitted on 1/18/16 and was an active client at the time of the licensing inspection. The annual physical exam was due to be completed by 1/18/17 but was not conducted until 2/10/17.

Client #5 was admitted on 2/8/13 and discharged on 9/15/17. The annual physical exam was due to be completed by 1/25/17 but was not conducted until 3/16/17.

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

Plan of Correction

Clinic Director will review inspection results with medical department regarding late annual physical exams on 12/29/17. The Clinic Director will monitor monthly the required annual physical exams to ensure that they are completed within timeframes for this standard.

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

Seven client records were reviewed on December 13, 2017, four of which were methadone client records; the facility failed to conduct an annual clinical evaluation on time for client #1.

Client #1 was admitted on 1/18/16 and was an active client at the time of the licensing inspection. The annual clinical evaluation was due to be completed by 1/18/17 but was not conducted until 2/8/17.

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

Plan of Correction

Clinic Director/Clinical Supervisor will provide a training on annual clinical evaluation time frames as 1 of 7 records reviewed was overdue. Training will occur on 01/10/18

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 December 13, 2017, four of which were methadone client records; the facility failed to update the treatment plan every 60 days in client records #1, 2, 3, 5 & 7.

Client #1 was admitted on 1/18/16 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 8/21/17; a treatment plan update was due by 10/21/17 but was not documented until 10/24/17.

Client #2 was admitted on 8/31/17 and was an active client at the time of the licensing inspection. A comprehensive treatment plan was documented on 10/5/17; a treatment plan update was due by 12/5/17 but was not documented until 12/8/17.

Client #3 was admitted on 2/15/16 and was an active client

Plan of Correction

Clinic Director/Clinical Supervisor will provide a training on treatment plan timeframes as a result of treatment plans being late or not completed. Clinic Director will ensure to provide all future auditors the treatment plan exception and highlight all those who are on 120 day treatment plans as one patient was incorrectly cited for 60 day treatment plan. This training will be provided on 01/10/18

at the time of the licensing inspection. A treatment plan update was documented on 8/29/17; a treatment plan update was due by 10/29/17 but was not documented until 10/31/17.

Client #5 was admitted on 2/8/13 and discharged on 9/15/17. A treatment plan update was documented on 5/19/17; a treatment plan update was due by 7/19/17 but was not documented at the time of the licensing inspection.

Client #7 was admitted on 4/19/17 and discharged on 8/16/17. A comprehensive treatment plan was documented on 5/19/17; a treatment plan update was due by 7/19/17 but was not documented until 7/21/17.

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

Return to Pennsylvania Department of Health Home Page