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.

WHITE DEER RUN OF YORK
106 DAVIES DRIVE
YORK, PA 17402

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/18/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and buprenorphine waiver monitorin that was conducted on March 18, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of York 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction
The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

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

Observations
Based on a review of the fire drill logs, the facility failed to document the completion of monthly unannounced fire drills. In addition, the facility failed to conduct a fire drill during

Plan of Correction
The Health and Safety Officer will develop a yearly calendar for fire drills to ensure that drills are conducted on every shift, including during sleeping hours a minimum of every six

sleeping hours at least every six months.

The findings include:

A review of the fire drill logs for the time period of January 2014 to December 2014 was conducted on March 18, 2015. The facility failed to document the completion of a monthly unannounced fire drill for October 2014 as well as document a second fire drill during sleeping hours as the only one conducted was on August 28, 2014.

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

months. All drills will be scheduled to occur prior to the 15th of the month. The Health and Safety Officer will submit the completed fire drill documentation to the Director within 24 business hours of completion of the drill. Drills that are not completed as scheduled by the 15th of the month will be rescheduled and conducted prior to month end.

709.28(a)(1) LICENSURE Confidentiality

709.28. Confidentiality. (a) A written procedure shall be developed by the project director which shall comply with 4 Pa. Code 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure shall include, but not be limited to: (1) Confidentiality of client identity and records.

Observations

Based on the review of client records, the facility failed to remain within the limits imposed by 4 Pa. Code 255.5 (b) in nine of ten records reviewed.

The findings included:

4 Pa. Code 255.5 states:

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

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

(2) Client's prognosis.

(3) The nature of the project.

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

(5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

Ten patient records were reviewed on March 18, 2015. The facility failed to stay within the limits imposed by 4 Pa. Code 255.5 (b) in client records 1, 3, 4, 5, 6, 7, 8, 9, and 10.

Plan of Correction

All staff responsible for providing patient care will be provided training on confidentiality laws and the limits pertaining to 4 Pa. Code 255.5. Clinical Supervisor and Nurse Manager will conduct monthly chart audits to ensure conformance to the confidentiality regulations.

Client record #1 contained an Admission Pennsylvania Client Placement Criteria dated September 22, 2014 that allowed for the release of client's drug of choice which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #3 contained an Admission Pennsylvania Client Placement Criteria dated October 23, 2014 that allowed for the release of client's drug of choice which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #4 contained an Admission Pennsylvania Client Placement Criteria dated October 13, 2014 that allowed for the release of client's drug of choice which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #5 contained an Admission Pennsylvania Client Placement Criteria dated October 27, 2014 that allowed for the release of client's drug of choice and medical condition which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #6 contained an Admission Pennsylvania Client Placement Criteria dated October 14, 2014 that allowed for the release of client's drug of choice which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #7 contained an Admission Pennsylvania Client Placement Criteria dated August 12, 2014 that allowed for the release of client's drug of choice and psychiatric diagnosis which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #8 contained an Admission Pennsylvania Client Placement Criteria dated August 19, 2014 that allowed for the release of client's drug of choice and medical condition which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #9 contained an Admission Pennsylvania Client Placement Criteria dated September 8, 2014 that allowed for the release of client's drug of choice and medical condition which exceeds what is permissible under 4 Pa. Code 255.5.

Client record #10 contained an Admission Pennsylvania Client Placement Criteria dated October 28, 2014 that allowed for the release of client's drug of choice which exceeds what is permissible under 4 Pa. Code 255.5.

These findings were reviewed with facility staff during the

licensing 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.

WHITE DEER RUN OF YORK
106 DAVIES DRIVE
YORK, PA 17402

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/15/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and inspection conducted for the approval to use a narcotic agent, specifically Buprenorphine, in the treatment of narcotic addiction. This inspection was conducted on March 15, 2016 by staff from the Department of Drug and Alcohol Programs Licensure Division. Based on the findings of the on-site inspection, White Deer Run of York, 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

705.7 (b) (5) LICENSURE Food service.
705.7. Food service. (b) A residential facility may operate a central food preparation area to provide food services to multiple facilities or locations. A residential facility that operates an onsite food preparation area or a central food preparation area shall: (5) Keep cold food at or below 40F, hot food at or above 140F, and frozen food at or below 0F.

Observations
Based on an observation during the physical plant inspection, the facility failed to keep frozen food at or below 0 degrees fahrenheit in two of two freezers.

The findings include:

A physical plant inspection was conducted on March 15, 2016 at approximately 9:30 am.

A freezer holding food that is located in the kitchen, had a thermometer that read 30 degrees fahrenheit. Additionally a freezer holding food that is located in the pantry room, had a thermometer that read 35 degrees fahrenheit. A second inspection took place in the afternoon where it was observed the freezer holding food that is located in the pantry room, had a thermometer that read 9 degrees fahrenheit.

Licensing specialist requested the facility's daily freezer temperature log book. Facility director could not provide documentation of the facility's daily freezer temperature logs from February 9, 2015 to the date of the inspection.

These findings were reviewed with facility staff during the

Plan of Correction
Each freezer will have the temperature recorded twice per day to ensure that the equipment is functioning within the required degrees. The cook will be responsible for recording the temperatures at the start of each shift and at the end of each shift. Any recordings outside of the identified range will be immediately evaluated for any necessary repairs. Program Director will conduct audits of the temperature logs to ensure compliance with this process.

licensing process.

705.10 (c) (4) LICENSURE Fire safety.

705.10. Fire safety. (c) Fire extinguisher. The residential facility shall: (4) Instruct all staff in the use of the fire extinguishers 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 a fire extinguisher upon staff employment, in one of five personnel records reviewed.

The findings include:

Five personnel records were reviewed on March 15, 2016. The facility failed to document the instruction of staff in the use of a fire extinguisher upon staff employment for employee #5.

Employee #5 was hired on January 11, 2016. The instruction of staff in the use of fire extinguisher was not documented until February 2, 2016.

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

Plan of Correction

All employees will receive Fire and Safety training for use of a fire extinguisher on the first day of employment. This will be incorporated into the Job Specific Orientation form with a required completion date for day one of orientation. Program Director will monitor compliance with this process through collection of all completed training certificates directly following each new hire's first day of employment.

705.10 (d) (3) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential 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 document the instruction of staff to perform assigned tasks during emergencies in one of five personnel records.

The findings include:

Five personnel records were reviewed on March 15, 2016. The facility failed to document the completion of emergency training in personnel record #5.

Employee # 5 was hired on January 11, 2016. Emergency training was not documented until February 2, 2016

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

Plan of Correction

All new employees will recieve emergency training on the first day of employment. This training will be incorporated into the Job Specific Orientation form with a required completion date of the first day of employment. Program Director will monitor compliance with this requirement through collection of the training certificates directly following the employee's first day of work.

705.10 (d) (4) LICENSURE Fire safety.

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

Observations

Based on the review of the fire drill record, the facility failed to ensure that fire drills were accurately documented on the fire drill reports.

The findings include:

The fire drill record was reviewed on March 15, 2016. Twelve months of fire drills were reviewed from the date of the last licensing inspection, 3/18/15. The facility's hours of operation are 24 hours a day, seven days a week.

The facility failed to document the time the fire drill took place for 06/28/15, 5/29/15 and 10/29/2015.

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

Plan of Correction

Facility staff will be provided training on the proper completion of the fire drill documentation to ensure thorough completion of all pertinent information on the form. Program Director will monitor compliance with this requirement by collecting and reviewing all fire drill documentation following each drill so that errors may promptly be addressed and drills repeated if necessary.

709.28(a)(1) LICENSURE Confidentiality

709.28. Confidentiality. (a) A written procedure shall be developed by the project director which shall comply with 4 Pa. Code 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure shall include, but not be limited to: (1) Confidentiality of client identity and records.

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent in eight of fifteen client records.

The findings include:

Fifteen client records were reviewed on March 15, 2016. The facility's consent to release client information was observed to be out of compliance with 42 CFR and State Law 4 Code 255.5 (b) in client records, #1, 4, 8, 9, 11, 12 and 15.

In addition, the "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

Client #1 was admitted on February 28, 2016, and was still an active client at the time of inspection. Consent forms

Plan of Correction

All staff responsible for completing consent forms with patients will be provided additional training on proper procedure for completing the consents to ensure the consent is valid. An additional line will be added to consents indicating the consent can be revoked verbally. All current clients will resign new consents with this added verbage. Nurse Manager will ensure that chart audits are completed on all new admissions to verify consents are completed correctly. Quality Manager is working with corporate to make changes to the consent document which will permanently address the issue.

dated 2/24/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #2 was admitted on February 26, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consents only allowed the client to revoke their consent forms in writing.

Client #4 was admitted on January 20, 2016 and was discharged on February 15, 2016. Consent forms dated 1/20/16, the facility failed to check off the purpose of the disclosure and what was to be released. In addition, the facility failed to comply with 42 CFR as the consents only allowed the client to revoke their consent forms in writing.

Client #8 was admitted on March 11, 2016, and was still an active client at the time of inspection. Consent forms dated 3/11/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #9 was admitted on March 14, 2016, and was still an active client at the time of inspection. Consent forms dated 3/14/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #11 was admitted on March 12, 2016, and was still an active client at the time of inspection. Consent forms dated 3/12/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources and government agencies. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #12 was admitted on March 9, 2016, transferred to inpatient rehab on March 15, 2016, and was still an active client at the time of inspection. Consent forms dated 3/9/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #15 was admitted on February 16, 2016, transferred to inpatient rehab February 21, 2016 and was still an active client at the time of inspection. Consent forms dated 2/16/16 allowed for the release of the client's alcohol, drug, or substance abuse records to funding sources. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

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

709.52(c) LICENSURE Provision of Counseling Services

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

Observations

Based on the review of client records, the project failed to ensure that counseling services were provided according to the individual treatment and rehabilitation plan in three of eleven client records reviewed.

The findings include:

Eleven client records were reviewed for counseling services during the renewal inspection on March 15, 2016. The project failed to ensure that clients received counseling services according to the client's individual treatment and rehabilitation plan in client records # 1, 4, and 6.

Client # 1 was admitted to the facility on February 28, 2016 and was still an active client at the time of inspection. Client #2's record contained a treatment plan dated 3/4/16 that identified the counseling services to be provided as individual therapy once per week and group therapy six times per week. The record did not contain documentation of any individual sessions from 3/6/2016 - 3/12/2016.

Client #4 was admitted to the facility on January 20, 2016 and discharged on February 15, 2016. Client #4's record contained a treatment plan dated 1/26/16 that identified the counseling services to be provided as individual therapy once per week and group therapy four times per week. The record did not contain documentation of any individual sessions from 1/31/16-2/6/2016. For that same week, the client only received two group counseling sessions. Additionally the record did not contain documentation of any individual or group sessions from 2/7/2016-2/14/2016.

Client #6 was admitted to the facility on September 23, 2015 and discharged on October 14, 2015. Client #6's record contained a treatment plan dated 9/25/15 that identified the counseling services to be provided as individual therapy once per week and group therapy four times per week. The record did not contain documentation of any individual sessions from 10/2/2015-10/9/2015.

Plan of Correction

Frequency of counseling services, both group and individual, will be properly documented on the record of services form in each patient's chart. A corresponding DAP note will be completed and filed within 24 hours of the service provided. Clinical Supervisor will conduct weekly open chart audits to ensure that all services provided have been properly documented.

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.

WHITE DEER RUN OF YORK
106 DAVIES DRIVE
YORK, PA 17402

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/07/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 6-7, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of York 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

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

Observations
Based on a review of facility records conducted as part of the presubmission process and during the onsite inspection, the facility failed to include all of the required documentation in its fire drill records.The fire drill records for 05/22/2016 and 11/23/2016 did not document whether or not the fire alarm or smoke detector was operative during the fire drill and the exit route used during the fire drill. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
1) Facility has added a Quality Improvement Coordinator position to work directly with the Health and Safety Officer to provide training to all staff responsible for documenting fire drills.

2) The process has been updated to include an immediate review of the documentation following each drill to ensure the documentation is completed accurately and in its entirety, with all pertinent information.

3) QI Coordinator will review drills conducted at the monthly Health & Safety Committee. If any drill documentation is not satisfactory, the drill will be conducted again during the month.

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 a review of patient records conducted during the onsite inspection, the facility failed to include all of the required information on its signed consent to release information forms in 1 of 12 patient records reviewed. The consent to release information to probation for patient #7 signed by the patient on 01/03/2017 did not document the purpose of the release. The consent to release information to Medicaid for patient #7 signed by the patient on 01/03/2017 did not document the purpose of the release.The consent to release information to the hospital for patient #7 signed by the patient on 01/03/2017 did not document the information to be released. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
1) Facility has revised the New Hire Orientation process to include having new hires practice completing a consent accurately during the training.

2) QI Coordinator will provide training to all new hires and existing staff responsible for completing consents with post-test assessment of competency.

3)Daily audits of each patient record will be conducted by the QI Coordinator or Charge Nurse to ensure consents are being completed accurately.

709.63(a)(7) LICENSURE Discharge summary

709.63. 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: (7) Discharge summary.

Observations

Based on a review of patient records conducted during the onsite inspection, the facility failed to document discharge summaries in 3 of 7 applicable detoxification records.Patient #1 was discharged on 11/30/2016.Patient #2 was discharged on 1/13/2017.Patient #3 was discharged on 12/17/2016. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

1)All outstanding Discharge Summaries will be completed on each chart indicated as deficient.

2)Facility has hired a Case Manager position that will be trained to support the nursing staff with completing discharge summaries within 7 days of discharge.

2)QI Coordinator will audit a representative sample of charts for each month to ensure compliance.

715.9(a)(2) 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: (2) Verify the individual 's identity, including name, address, date of birth, emergency contact and other identifying data.

Observations

Based on a review of facility records conducted during the onsite inspection, the facility failed to verify the identity of 1 of 4 patients admitted for narcotic treatment.Patient #3 was admitted for treatment on 12/14/2016 and discharged on 12/17/2016. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

1)QI Coordinator will provide training to the new Intake Technician and newly hired Nursing staff on the admission process and identity verification requirements for narcotic treatment.

2)Medication Administration Records will contain a copy of the patient ID obtained at admission to verify identity prior to dosing.

3) Daily audits will be conducted by the QI Coordinator or Charge Nurse to ensure compliance.

4) QI Coordinator will conduct quarterly audits on a representative sample to ensure compliance.

709.52(a)(2) LICENSURE Tx type & frequency

709.52. 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: (2) Type and frequency of treatment and rehabilitation services.

Observations

Based on review of patient records, the facility failed to follow the individualized treatment plan in 2 of 4 applicable records reviewed.Patient #9 was admitted for residential treatment and rehabilitation on 08/02/2016 and was discharged from treatment on 08/12/2016. The patient's individualized treatment plan dated 08/05/2016 listed 6 groups counseling sessions per week, but the patient only had group counseling on 08/08/2016.Patient #10 was admitted for residential treatment and rehabilitation on 09/27/2016 and was discharged from treatment on 10/11/2016. The patient's individualized treatment plan dated 09/30/2016 listed 6 groups counseling sessions per week, but the patient only had group counseling on 10/02/2016 and 10/06/2016. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Clinical group counseling was provided 6 times per week, however, the assigned counselors failed to document each service provided in the patient records, despite patient attendance at the group. The assigned counselor also did not individualize the number of groups to be provided for each patient.

1)Clinical Coordinator will individualize each patient's treatment plan to indicate the number of group counseling services to be provided.

2) Clinical Coordinator will complete a DAP note for all clinical group services provided for each patient.

3) QI Coordinator will conduct an audit on a representative sample of charts for each month to ensure that group counseling services are being provided and documented according to the treatment plan.

709.53(a)(10) LICENSURE Discharge Summary

709.53. 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: (10) Discharge summary.

Observations

Plan of Correction

Based on a review of patient records conducted during the onsite inspection, the facility failed to document discharge summaries in 4 of 5 applicable residential treatment and rehabilitation records.Patient #8 was discharged on 6/14/2016.Patient #10 was discharged on 10/11/2016.Patient #11 was discharged on 09/09/2016. Patient #12 was discharged on 06/14/16. These findings were reviewed with facility staff as part of the inspection process.	1) Discharge Summaries will be completed for all charts reviewed and identified with deficiencies. 2) Facility has hired a Case Manager position that will be trained to support the nursing staff with completing discharge summaries within 7 days of discharge. 3)QI Coordinator will audit a representative sample of charts for each month to ensure compliance.

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.

WHITE DEER RUN OF YORK
106 DAVIES DRIVE
YORK, PA 17402

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 06/15/2017

INITIAL COMMENTS

This report is a result of a supervisory review of the written report of the findings of an on-site licensure inspection that was conducted on April 6 & 7, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the supervisory review of findings from the on-site inspection, White Deer Run of York, 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 supervisory review:

Plan of Correction

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

Observations
Based upon a review of the Staff listed on the Staffing Requirements Facility Summary Report form (SRFSR) completed by the facilty, the facility failed to list all staff that were working at the facility.

The SRFSR listed individuals serving as primary care staff for the detoxification unit that were not listed as facility employees or contracted staff anywhere else on the SRFSR clinical staff, other employees any where else on the SRFSR form.

Following the review of an additional document identifying agency nursing staff, it was determined that two individuals serving as primary care staff for the detoxification unit were not listed on the newly submitted document.

Plan of Correction
Upon review of the submitted staffing roster, it appears that one agency staff person was not included on the roster, although credentials were included in the packet for this staff person. The facility will submit an updated roster to include this individual's name, position and date of hire (date first worked in the facility). All future rosters will include agency staff used on the initial submission.

704.12(a)(1)(i) LICENSURE Client/couns ratios
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. (1) Inpatient nonhospital detoxification (residential detoxification). (i) There shall be one FTE primary care staff person available for every seven clients during primary care hours.

Observations
Based upon a review of the Staff listed on the Staffing Requirements Facility Summary Report form (SRFSR) completed by the facilty, the facility was not able to verify

Plan of Correction
Upon review of the submitted staff schedule for the detoxification activity, it appears that the facility failed to include the full name of individual #2 and individual #1 was

that one primary care staff for every seven clients.

The SRFSR listed individuals serving as primary care staff for the detoxification unit that were not listed as facility employees or contracted staff anywhere else on the SRFSR clinical staff, other employees any where else on the SRFSR form.

Following the review of an additional document identifying agency nursing staff, it was determined that two individuals serving as primary care staff for the detoxification unit were not listed on the newly submitted document.

Individual #1 was on the schedule as the third of three required staff working in the detox unit from 7:00AM - 7:00 PM on Sunday at the beginning of the week and Friday and Saturday at the end of the week for 20 clients on Sunday 21 clients on Friday and 19 clients on Saturday.

Individual #2 was on the schedule as the second of three required staff working in the detox unit from 7:00AM - 7:00 PM on Saturday at the end of the week for 19 clients

not listed on the staffing roster. The facility will update the schedule to include full names of all staff and will also submit the updated roster to include the name of individual #1 as an agency staff person working on that date. All future submissions of staff rosters will include full names of agency staff working as primary care and these staff will also be included on the staff roster.

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.

WHITE DEER RUN OF YORK
106 DAVIES DRIVE
YORK, PA 17402

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/25/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 24, 2018 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, White Deer Run of York 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

705.10 (d) (5) LICENSURE Fire safety.
705.10. Fire safety. (d) Fire drills. The residential facility shall: (5) Conduct a fire drill during sleeping hours at least every 6 months.

Observations
The facility failed to conduct a fire drill during sleeping hours at least once every six months.Fire drill logs for January - December, 2017 and January- March, 2018 were reviewed on April 24, 2018. An overnight fire drill was documented on March 3, 2017. The next documented overnight fire drill was November 28, 2017. These finding were reviewed with facility staff during the licensing inspection.

Plan of Correction
White Deer Run of York will conduct a fire drill during sleeping hours twice a year and no later than six months from the last sleeping hours fire drill.

White Deer Run of York Quality Improvement Coordinator will monitor all drills for compliance.

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

Observations
The facility failed to document an annual written individual staff performance evaluation in one of three personnel records reviewed on April 24, 2018. In personnel record # 2, there was no documentation provided of a 2017 annual evaluation. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
White Deer Run of York leadership will review upcoming annual performance evaluations and complete them with employees on a monthly basis.

Completed annual performance evaluations will be sent to the HR department to be filed in the employee's personnel record.

White Deer Run HR Department will monitor for compliance.

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	Plan of Correction
The narcotic treatment program failed to have a narcotic treatment physician make a face-to face determination in six of seven records reviewed on April 24, 2018. In patient records #1, 2, 4, 5, 6 and 7, the CRNP completed the face to face determination. Inpatient record # 1, the face to face was completed by the CRNP on April 20, 2018 and the patient was initially dosed on April 20, 2018. The narcotic treatment physician signed off on the face to face completed by the CRNP on April 21, 2018. There was no documentation that the patient was seen face to face by the narcotic treatment physician prior to initial dose. Inpatient record # 2, the face to face was completed by the CRNP on April 21, 2018 and the patient was initially dosed on April 21, 2018. The narcotic treatment physician signed off on the face to face completed by the CRNP on April 22, 2018. There was no documentation that the patient was seen face to face by the narcotic treatment physician prior to initial dose. Inpatient record # 4 the face to face was completed by the CRNP on October 8, 2017. The patient was initially dosed on October 9, 2017. The narcotic treatment physician signed off on the face to face completed by the CRNP on October 9, 2017. There was no documentation that the patient was seen face to face by the narcotic treatment physician prior to initial dose. Inpatient record # 5 the face to face was completed by the CRNP on March 6, 2018. The patient was initially dosed on March 7, 2018. The narcotic treatment physician signed off on the face to face completed by the CRNP on March 7, 2017. There was no documentation that the patient was seen face to face by the narcotic treatment physician after initial dose. Inpatient record # 6 the face to face was completed by the CRNP on January 5, 2018. The patient was initially dosed on January 5, 2018. There was no documentation that the narcotic treatment physician signed off on the face to face completed by the CRNP. There was no documentation that the patient was seen face to face by the narcotic treatment physician prior to initial dose. Inpatient record # 7 the face to face was completed by the CRNP on October 1, 2017. The patient was initially dosed on October 1, 2017. There was no documentation that the narcotic treatment physician signed off on the face to face completed by the CRNP. There was no documentation that the patient was seen face to face by the narcotic treatment physician prior to initial dose. These findings were reviewed with facility staff during the licening inspection.	White Deer Run of York narcotic treatment physician will complete the face to face opiate dependency determination on all patients prior to administration of Buprenorphine. Documentation of the face to face determination will be captured using an Opiate Dependency Checklist, which will be signed by the narcotic treatment physician. White Deer Run of York Nursing Supervisor will audit a representative sample of records each month to ensure compliance.

715.15(b) LICENSURE Medication dosage

(b) The narcotic treatment physician shall determine the proper dosage level for a patient, except as otherwise provided in this section. If the narcotic treatment physician determining the initial dose is not the narcotic treatment physician who conducted the patient examination, the narcotic treatment physician shall consult with the narcotic treatment physician who performed the examination before determining the patient 's initial dose and schedule.

Observations	Plan of Correction
The facility failed to document that the narcotic treatment physician determined the proper dosage level for a patient in six of seven patient records reviewed on April 24, 2018. The CRNP determined the doseage level for the patient in patient records # 1, 2, 4, 5, 6 and 7. These findings were reviewed with facility staff during the licensing inspection.	White Deer Run of York narcotic treatment physician will determine the proper dosage level for each patient after completion of the face to face opiate dependency determination and prior to administration of Buprenorphine. The narcotic treatment physician will also determine dose changes for patients.

White Deer Run of York Nursing Supervisor will audit a representative sample of records each month to ensure compliance.

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.

WHITE DEER RUN OF WILLIAMSPORT

520 WEST FOURTH STREET, SUITE 3D
WILLIAMSPORT, PA 17701

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/11/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 11, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Williamsport 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

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

704.11. Staff development program. (f) Training requirements for counselors. (2) Each counselor shall complete at least 25 clock hours of training annually in areas such as: (i) Client recordkeeping. (ii) Confidentiality. (iii) Pharmacology. (iv) Treatment planning. (v) Counseling techniques. (vi) Drug and alcohol assessment. (vii) Codependency. (viii) Adult Children of Alcoholics (ACOA) issues. (ix) Disease of addiction. (x) Aftercare planning. (xi) Principles of Alcoholics Anonymous and Narcotics Anonymous. (xii) Ethics. (xiii) Substance abuse trends. (xiv) Interaction of addiction and mental illness. (xv)

Cultural awareness. (xvi) Sexual harassment. (xvii) Developmental psychology. (xviii) Relapse prevention. (3) If a counselor has been designated as lead counselor supervising other counselors, the training shall include courses appropriate to the functions of this position and a Department approved core curriculum or comparable training in supervision.

Observations

Based on a review of personnel records, the facility failed to document the completion of 25 clock hours of annual training required for counselors in one of three personnel records reviewed.

The findings included:

Four personnel records were reviewed on March 11, 2015. Three personnel records were reviewed for the position of counselor. One of the three counselor records reviewed were reviewed for 25 clock hours of annual training. The facility failed to document 25 clock hours of annual training in personnel record #2

Employee # 2 was hired on July 5, 2000. The facility training year for January to December 2014 was reviewed. Employee # 2 only completed 1.5 clock hours of annual training in 2014.

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

Plan of Correction

Clinical Supervisor met with Employee # 2 on 3-24-2015 to discuss and review expectations regarding required training hours to be 25 in a year and documented with Quality Improvement and clinical supervisor. Employee #2 and all employees at this location are instructed to complete at least 6 training hours per quarter throughout 2015. The clinical supervisor will follow-up with employee #2 and all employees during quarterly supervision to determine compliance with the recommended procedure adhering to 704.11 required training hours.

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.

WHITE DEER RUN OF WILLIAMSPORT

520 WEST FOURTH STREET, SUITE 3D
WILLIAMSPORT, PA 17701

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/08/2015

INITIAL COMMENTS

This report is a result of an on-site Unusual Incident investigation conducted on April 8, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the on-site investigation, White Deer Run 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

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.

WHITE DEER RUN OF WILLIAMSPORT
520 WEST FOURTH STREET, SUITE 3D
WILLIAMSPORT, PA 17701

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/21/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 21, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Williamsport, 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

705.22 (4) LICENSURE Building exterior and grounds.
705.22. Building exterior and grounds. The nonresidential facility shall: (4) Store all trash, garbage and rubbish in noncombustible, covered containers that prevent the penetration of insects and rodents, and remove it at least once every week.

Observations
Based on observation during a physical plant inspection, the facility failed to ensure that all trash, garbage and rubbish was stored in noncombustible, covered containers that prevent the penetration of insects and rodents.

The findings include:

An initial physical plant inspection was conducted on March 21, 2016 at approximately 11:00 AM.

The dumpster was observed to be full and overflowing with trash bags so that the lid could not close.

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

Plan of Correction
During staffing meeting on March 22, 2016, a plan was developed and discussed that each day the safety officer and staff will observe and evaluate at 8am and 3pm the dumpsters capacity to avoid overflow. The landlord and facility director will be contacted immediately if the dumpster is boardering a potential overflow prior to the routine pick-up by contracted hauler to assure ongoing compliance with this standard and the safety of our clients.

The facility will immeditely contact the landlord to correct the issue and monitor throughout the day with continuous phone calls until the issue is resolved. Staff at the location will contact the Regional Director who will in turn contact the landlord to resolve the issue the day of the potential overflow. Monitoring the dumpster daily will assure that it does not get to the point of when the lid cannot be closed.

705.27 (4) (i) LICENSURE General safety and emergency procedures.
705.27. General safety and emergency procedures. The nonresidential facility shall: (4) Provide written procedures for staff and clients to follow in case of an emergency which shall include provisions for: (i) The evacuation and transfer of clients and staff to a safe location.

Observations
Based on a review of personnel records, the facility failed to ensure that all personnel on all shifts are trained to perform

Plan of Correction
The Regional Director has reviewed this standard and will upon hire of employees will personally complete the

assigned tasks during emergencies in one of four personnel records reviewed.

The findings include:

Four personnel records were reviewed on March 21, 2016. The facility failed to document that the emergency training was completed for employee, # 4.

Employee # 4 was hired on September 29, 2015. Emergency training was due to be completed no later than October 6, 2015. The facility did not document the completion of emergency training until October 13, 2015.

The findings were reviewed with staff during the licensing inspection.

paperwork with signatures and initials during the time of orientation which is held within 7 days of the start date. All newly hired employees paperwork will be submitted to human resource department for review within 7 days of start date. A review of this standard and newly hired staff will be followed up with the safety officer report during weekly staffing meetings.

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 instruct staff in the use of a fire extinguisher upon staff employment for one of four personnel records reviewed.

The findings include:

Four personnel records were reviewed on March 21, 2016. The facility failed to document that the fire extinguisher training was completed upon employment for employee #4.

Employee # 4 was hired on September 29, 2015. Fire extinguisher training was due to be completed no later than October 6, 2015. The facility did not document the completion of fire extinguisher training until October 13, 2015.

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

Plan of Correction

The Regional Director has reviewed this standard and will upon hire of employees will personally complete the paperwork with signatures and initials during the time of orientation which is held within 7 days of the start date. All newly hired employees paperwork will be submitted to human resource department for review within 7 days of start date. A review of this standard and newly hired staff will be followed up with the safety officer report during weekly staffing meetings.

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 a review of client records, the facility failed to obtain an informed and voluntary consent in four of nine client records.

Plan of Correction

The regional director will complete an onsite training on April 26, 2016 to review this standard that clients do have the right to revoke a consent verbally. All active clients consents will be reviewed with the clients and their primary counelor

The findings include:

Nine client records were reviewed on March 21, 2016. The facility's consent to release client information was observed to be out of compliance with 42 CFR and State Law 4 Code 255.5 (b) in client records, #3, 4, 8, and 9.

In addition, the "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

Client #3 was admitted on January 19, 2016, and was still an active client at the time of inspection. Consent forms dated 3/17/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to a government agency. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #4 was admitted on February 17, 2016, and was still an active client at the time of inspection. Consent forms dated 2/17/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to funding sources and a government agency. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #8 was admitted on August 15, 2015 and was discharged on January 11, 2016. The facility failed to comply with 42 CFR as the consents only allowed the client to revoke their consent forms in writing on a consent dated 1/11/16.

Client #9 was admitted on December 17, 2015 and was discharged on February 8, 2016. The facility failed to comply with 42 CFR as the consents only allowed the client to revoke their consent forms in writing on a consent dated 12/17/15.

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

to have written in to the existing consent the following statement: "This consent can be verbally revoked" where by both the client and staff will initial and date. All consents for active clients will be updated by May 6, 2016. The regional director will monitor compliance with this standard through random chart audit reviews. At least 3 active client files will be reviewed weekly and further monitored through monthly and quarterly supervision.

The Quality Managment Director and Regional Vice President are working with corporate to assure that the current consents are 255.5 compliant.

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.

WHITE DEER RUN OF WILLIAMSPORT
520 WEST FOURTH STREET, SUITE 3D
WILLIAMSPORT, PA 17701

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/20/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 20, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Williamsport 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

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

The facility failed to provide a physician signature on treatment plans and treatment plan updates in three of three client records. Eight client records were reviewed on April 20, 2017. Three of the seven clients reviewed were funded by medical assistance and were required to have a physician signature on the treatment plans and updates. The treatment plans and/or updates in client records #1, 3 and 4 were not signed by a physician. The facility's physician assistant signed the documents in place of the physician.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The facility director of the OP facility has assigned staff(office manager) at the OP program to coordinate with the director of nursing staff at the residential program of White Deer Run, located at Allenwood. The coordination will involve a review of the Physicians schedule so as to have files of clients funded by Medical Assistance to be signed weekly by a physician within that program. A designated driver for WDR residential will transport those files to the residential facility for physicians signature and returned within 24 hours to the OP facility. This process has started the week of May 1st, 2017 and will continue while the medical director of the OP facility is listed as the medical director of the residential facility. Ongoing monthly chart reviews of active and closed files will assure that the appropriate medical personnel is signing off of MA funded clients files.

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.

WHITE DEER RUN OF WILLIAMSPORT
520 WEST FOURTH STREET, SUITE 3D
WILLIAMSPORT, PA 17701

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/03/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 3, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Williamsport 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

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 a review of facility records conducted during the on-site inspection, the facility failed to ensure that it obtained informed voluntary consents before disclosing client information in 4 client records reviewed.

Plan of Correction

The Facility Director of the OP program will review with staff how to properly complete release of information to ensure that all areas of the release are completed before disclosing information.

Client #1 was admitted for treatment on 3/19/2018, and was an active client in treatment at the time of the on-site inspection. The client's release of information for probation dated 3/29/2018, did not document the purpose of the release, or the information to be disclosed in the release.

Supervisor will assure that all active open files will have a corrected ROI signed by the client.

If the client file is closed due to discharge then all communication will cease.

Client #2 was admitted for treatment on 3/05/2018, and was an active client in treatment at the time of the on-site inspection. The client's release of information for the client's treatment funding source, and the client's release of information for the county's case management unit both dated 3/05/2018, did not document the purpose of the releases, or the information to be disclosed in the releases.

Review with staff will be completed by May 25th, 2018.

Supervisor will complete monthly and quarterly chart audits to assure compliance in this standard.

Client #3 was admitted for treatment on 1/11/2018, and was an active client in treatment at the time of the on-site inspection. The client's release of information for the client's treatment funding source, and the client's release of information for the county's case management unit both dated 1/11/2018, did not document the purpose of the releases, or the information to be disclosed in the releases.

Client #4 was admitted for treatment on 7/26/2017, and was discharged on 12/07/2017. The client's release of information for probation dated 7/26/2017, did not document the purpose of the release, or the information to be disclosed in the release.

These findings were reviewed with facility staff as part of 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.

WHITE DEER RUN LLC. - NEW CASTLE
413 HIGHLAND AVENUE
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/23/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 23, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run Inc. - New Castle 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 Staffing Requirements Facility Summary Report forms for all of the facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

Completion date July 1, 2015.

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.

WHITE DEER RUN LLC. - NEW CASTLE

413 HIGHLAND AVENUE
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/16/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal inspection conducted on March 16, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, White Deer Run Inc. - New Castle 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 inspection and 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.

WHITE DEER RUN LLC. - NEW CASTLE
413 HIGHLAND AVENUE
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/12/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 12, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run Inc. - New Castle 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

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
The facility failed to obtain an informed and voluntary consent from the client for the disclosure of information in seven of seven client records reviewed during the annual licensing inspection conducted on April 12, 2017.Urine samples were sent to a laboratory for analysis during the intake process and at random times throughout treatment without the client's written consent or a Qualified Service Organization Agreement (QSOA) in the following client records:Client # 1 was admitted August 25, 2016 and discharged on December 15, 2016.Client # 2 was admitted June 6, 2016 and discharged on August 19, 2016.Client # 3 was admitted October 6, 2016 and discharged on January 10, 2017.Client # 4 was admitted August 31, 2016 and discharged on March 3, 2017.Client # 5 was admitted November 15, 2016.Client # 6 was admitted June 29, 2016.Client # 7 was admitted September 13, 2016.The findings were reviewed with facility staff during the licensing process.

Plan of Correction
Clinical Director corrected this and a QSOA was obtained 4-18-17.

Clinical Director will ensure that if lab changes in the future a new QSOA will be obtained or client's will sign a consent to release information.

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.

WHITE DEER RUN LLC. - NEW CASTLE

413 HIGHLAND AVENUE
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 05/03/2018

INITIAL COMMENTS

This report is a result of an on-site licensure inspection conducted on May 3, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, LLC- New Castle 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 inspection and 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.

WHITE DEER RUN OF LEWISBURG
115 FARLEY CIRCLE, SUITE 303
LEWISBURG, PA 17837

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/02/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 2, 2015, by staff from the Department of Drug and Alcohol Programs, Program Licensure Division. Based on the findings of the on-site inspection, White Deer Run of Lewisburg 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.The findings include:The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.The findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

Completion date July 1, 2015.

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

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

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

Plan of Correction
Counselors will achieve 25 hours annually in approved trainings. Counselors will be responsible for finding trainings

required for counselors in one of three personnel records reviewed.The findings included:Five personnel records were reviewed on March 2, 2015. One of the three counselor records reviewed were reviewed for 25 clock hours of annual training. The facility failed to document 25 clock hours of annual training in personnel record #2Employee # 2 was hired on June 3, 2003. The facility training year for January to December 2014 was reviewed. Employee # 2 only completed 15.5 clock hours of annual training in 2014.These findings were reviewed with facility staff during the licensing process.

throughout the year and scheduling with their supervisor when these trainings will occur so that the supervisor can find coverage for that date. Upon completing a training, counseling staff will submit a copy of their training certificate and evaluation to QI coordinator to track their training hours. Employee #2 has been instructed to complete at least 6 training hours per quarter throughout 2015. The clinical supervisor will follow-up with all staff during quarterly supervision to determine compliance with 704.11 required training hours for counselors and follow -up of the recommended procedure for completing the required hours.

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.

WHITE DEER RUN OF LEWISBURG
115 FARLEY CIRCLE, SUITE 303
LEWISBURG, PA 17837

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/25/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 25, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Lewisburg, 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

709.28(c) LICENSURE Confidentiality

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

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent in three of seventeen client records.The findings include:Seventeen client records were reviewed on March 25, 2016. The facility's consent to release client information was observed to be out of compliance with 42 CFR and State Law 4 Code 255.5 (b) in client records, #1, 14 and 16.In addition, the "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."Client #1 was admitted on March 20, 2015, and discharged from treatment on January 6, 2016. Consent forms allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to a funding source. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing. Client #14 was admitted on January 14, 2016, and was an active client at the time of inspection. Consent forms dated 1/14/16 allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to a funding source. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing. Client #16 was admitted on January 13, 2016, and was an active client at the time of inspection. Consent forms dated January 13, 2016allowed for the release of the client's alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to a funding source. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing. These findings were reviewed

Plan of Correction

The regional director conducted an onsite training on April 20, 2016 reviewing this standard that clients do have the right to revoke a consent verbally. All active clients consents will be reviewed with the clients during the next 2 weeks of appointments with their primary counselor to have written in to the existing consent the following statement: "This consent can be verbally revoked" where by both the client and staff will initial and date. All consents for active clients will be updated by May 6, 2016. The regional director will monitor compliance with this standard through random chart audit reviews. At least 3 active client files will be reviewed weekly and further monitored through monthly and quarterly supervision.

The Quality Managment Director and Regional Vice President are working with corporate to assure that the current consents are 255.5 compliant.

with facility staff during the licensing process.

709.33(a) LICENSURE Notification of Termination

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

Observations

Based on a review of client records, the facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project in one of four client records.The findings include:Four client records requiring written notification to the client of facility's decision to involuntarily terminate the client's treatment were reviewed on March 25, 2016. The facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the facility in client record #5.Client # 5 was admitted into treatment on August 27, 2015 and was involuntarily terminated from the facility on November 2, 2015. There was no documentation of written notification of the facility's decision to involuntarily terminate the client's treatment as of the date of the on-site inspection.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

An onsite training occurred on April 13, 2016 to review this standard and the procedure for notifying clients by letter of termination of their treatment episode with our agency. It was further reviewed that letters are sent to the client and a copy of the letter is filed in the client file retained at the facility. Random monthly chart audits and supervision by the regional director to monitor ongoing compliance with this standard.

709.91(b)(6) LICENSURE Intake and admission

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

Observations

Based on a review of client records, the facility failed to provide a psychosocial evaluation to include the client's problems/needs, assets/strengths, support systems, coping mechanisms, negative factors that may inhibit treatment and/or counselor conclusions and impressions in four of seventeen records reviewed. The findings include:Seventeen client records were reviewed on March 25, 2016. The psychosocial evaluations in client records # 3, 6, 10 and 11 did not include an evaluation of the client's problems/needs, assets/strengths, coping mechanisms, support services, and how they would impact treatment prior to completion of the individual treatment and rehabilitation plan. Additionally, the facility failed to provide a composite picture by the counselor along with conclustions/impressions of the client in client records #3, 6, 10 and 11 prior to the completion of the individual treatment and rehabilitation plan. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

An onsite training occurred on April 13, 2016 to review this standard of a summary or conclusion of the counselors impression which is the final part of the psychosocial evaluation identifying the client's strengths, needs, barriers, supports and coping strategies. Random monthly chart audits and supervision by the regional director to monitor ongoing compliance with this standard.

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 progress notes, aftercare plans, and/or discharge summary in of five of seventeen client records.The findings include:Seventeen client records requiring a complete client record including documentation of progress notes, , aftercare plan, and discharge summary were reviewed March 25, 2016. The facility failed to document progress notes in client records # 2 and #5. Client # 2 was admitted on December 3, 2015 and was discharged from treatment on February 8, 2016. There were no progress notes after the January 20, 2016 treatment session.Client # 5 was admitted on August 27, 2015 and was discharged from treatment on November 2, 2015. There were no progress notes after the October 14, 2015 treatment

Plan of Correction

An onsite training occurred on April 13, 2016 to review this standard of documenting complete records during the client's length of stay and upon discharge. A review of timeliness of when progress notes are commpleted, aftercare plans, and discharge summaries are due. Random monthly chart audits of active and closed files by the regional director to assure ongoing compliance with this standard. Monthly supervision to review these audits.

session.The facility failed to document an aftercare plan in client record # 2. Client # 2 was admitted on December 3, 2015 and was discharged from treatment on February 8, 2016. The facility failed to document a discharge summary in client records # 2, 5, 8, 10, 13.Client # 2 was admitted on December 3, 2015 and was discharged from treatment on February 8, 2016. Client # 5 was admitted on August 27, 2015 and was discharged from treatment on November 2, 2015. Client #8 was admitted on April 27, 2015 and was discharged from treatment on March 4, 2016.Client #10 was admitted on November 25, 2015 and was discharged from treatment on February 1, 2016.Client #13 was admitted on August 24, 2015 and was discharged from treatment on January 27, 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 client records, the facility failed to document a physician signature on the individual treatment plans for medical assistance clients in one of nine client records requiring the signature.The findings included:Seventeen client records were reviewed on March 25, 2016. Nine of the seventeen client records are required to have a physician signature on the individual treatment plans. The individual treatment plans contained in client record #1, did not contain a physician signature.Client #1 was admitted to outpatient treatment on March 20, 2015. The individual treatment and rehabilitation plan was developed on April 2, 2015, with updated plans on May 20, 2015, July 20, 2015, September 21, 2015 and November 19, 2015. None of these plans included a physician signature. The findings were reviewed with the facility director and the clinical supervisor and were not disputed.

Plan of Correction

An onsite training and discussion occurred on April 13, 2016 to review this standard and the current procedure in place for the contracted off site Doctor to sign off on medical assistance files. Every 2 weeks during staffing meetings the caseloads will be reviewed of medical assistance funded clients to assure the required documents to be signed are marked to be signed or signed by the Doctor who visits the office twice a month. Random monthly chart audits and supervision by the regional director to monitor ongoing compliance with this standard.

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.

WHITE DEER RUN OF LEWISBURG
115 FARLEY CIRCLE, SUITE 303
LEWISBURG, PA 17837

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/27/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 27, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Lewisburg 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(f)(2) LICENSURE Trng Hours Req-Coun

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

Observations
The facility failed to document that each counselor completed 25 hours of training annually.Three staff records were reviewed on April 27, 2017. One of the records reviewed was for a counselor and required documentation of 25 hours of training for the 2016 training year.Staff #3 was hired as a counselor on 8/18/14. Staff #3 completed 21 hours of training for the 2016 training year.These findings were reviewed with facility staff during the licensing process.

Plan of Correction
Counselors will achieve 25 hours annually in approved trainings. Counselors will be responsible for finding trainings throughout the year and scheduling with their supervisor for approval. Upon completing a training, counseling staff will submit a copy of their training certificate and evaluation to QI coordinator to track their training hours. Employee #3 has been instructed to complete at least 6 training hours per quarter throughout 2017 so that the required hours will be completed prior to years end. The clinical supervisor will follow-up with all staff during quarterly supervision to determine compliance with 704.11 required training hours for counselors and follow -up of the recommended procedure for completing the required hours.

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.

WHITE DEER RUN OF LEWISBURG
115 FARLEY CIRCLE, SUITE 303
LEWISBURG, PA 17837

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/30/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 30, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Lewisburg 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

709.28 (c) (4) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (4) Dated signature of client or guardian as provided for under 42 CFR 2.14(a) and (b) and 2.15 (relating to minor patients; and incompetent and deceased patients).

Observations

Based on a review of facility records conducted during the on-site inspection, the facility failed to obtain accurate dates for client signatures on consent to release information forms.

Plan of Correction

The Facility Director of the OP program will review with staff how to properly complete releases of information to ensure all areas of release are completed before disclosing information.

Client #6 was admitted for treatment on 08/15/2017, but the client's signature for the release of information for the client's mother was dated 11/17/2015.

Supervisor will assure that all active open files will have a corrected ROI signed by the client.

Client #6 was admitted for treatment on 08/15/2017, but the client's signature for the release of information for probation was dated 08/17/2015.

If the client file is closed due to discharge then all communication will cease.

These findings were reviewed with facility staff as part of the inspection process.

This will be completed with staff by May 25th, 2018.

This will be monitored with monthly chart audits.

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.

LEHIGH COUNTY CENTER FOR RECOVERY
1620 RIVERSIDE DRIVE
BETHLEHEM, PA 18015

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/19/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 19, 2015 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, Lehigh County Center For Recovery 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction
The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors 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. The consent shall be in writing and include, but not be limited to:

Observations
Based on the review of client records, the facility failed to

Plan of Correction
Staff documenting or having access to the patient chart will

ensure that an informed and voluntary consent to release information was complete and/or obtained in three of eleven client records reviewed.

The findings included:

Eleven client records requiring complete informed and voluntary consent to release information forms were reviewed on March 19, 2015. The facility failed to ensure that an informed and voluntary consent to release information was obtained in client records, #7 and 9. Additionally, the facility failed to ensure that the purpose of the disclosure of client information was completed on the consent to release information form in client records, #7 and 8.

Client #7 was admitted to treatment on October 8, 2014 and was discharged on October 13, 2014. A release of information to a government agency was in the chart, but was not signed and dated by the client or witness. Additionally, the same release of information was within the limits established by 4 Pa. Code 255.5 (b) for releases of information, but it did not provide the purpose of the disclosure.

Client #8 was admitted to treatment on September 16, 2014 and was discharged on October 2, 2014. A release of information to a government agency was signed and dated by the client on September 16, 2014, but there was no purpose of the disclosure provided.

Client #9 was admitted to treatment on December 30, 2014 and was discharged on January 12, 2015. The facility failed to include a release of information to the client's insurance company for billing purposes.

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

be re-trained on Confidentiality and Completion of Consent to Release forms no later than April 29th. Clinical Supervisor and Nursing Supervisor will maintain ongoing compliance through chart audits over the next 60 days by reviewing no less than 10% of the open charts. Noncompliance will result in individual employee improvement plans.

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.

LEHIGH COUNTY CENTER FOR RECOVERY
1620 RIVERSIDE DRIVE
BETHLEHEM, PA 18015

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/04/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 4, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Lehigh County Center for Recovery 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(f)(2) LICENSURE Trng Hours Req-Coun

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

Observations

Based on a review of personnel records, the facility failed to document the completion of 25 clock hours of annual training required for counselors in one of one personnel record reviewed.

The findings include:

One personnel record of a counselor requiring the documentation of the completion of 25 clock hours of annual training was reviewed on April 4, 2016 . The facility failed to document the completion of 25 clock hours of annual training for employee # 3.

Employee # 3 was hired on May 8, 2013 as a counselor. The facility training year is from January through December. The training year for January 2015 to December 2015 was reviewed. Employee # 3 had 18.5 hours of training documented for the 2015 training year.

Plan of Correction

704.11 Training Hours Required-Counselor

The facility failed to document 25 clock hours of annual training for employee # 3.

POC

The Clinical Supervisor will review training plans with each counselor on a monthly basis to ensure that adequate training hours are documented throughout the year. This will commence 4/14/16. Person responsible for oversight and implementation is the Clinical Supervisor.

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

709.28(c) LICENSURE Confidentiality

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

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent in eleven of twelve client records.

The findings include:

4 Pa. Code 255.5 states:

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

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

(2) Client's prognosis.

(3) The nature of the project.

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

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

Twelve client records were reviewed on April 4, 2016. The facility's consent to release was observed to be out of compliance with 42 CFR and State Law 4 Code 255.5 (b) in client records, #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11.

In addition, the "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

Client #1 was admitted on March 31, 2016 and was still an active client at the time of inspection. On a consent form dated 3/31/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to probation thus exceeded the limitations

Plan of Correction

709.28(c) Confidentiality

The facility's consent to release was observed to be out of compliance with 42 CFR and State Law 4 Code 255.5 (b).

POC

System facilities will review and revise consent to release forms to be in compliance with 42 CFR and State Law 4 PA Code 255.5(b). Section to be removed related to the release of Alcohol, Drug, Substance Abuse Records, HIV Testing and Results and Mental Health Records.

Responsibility for insuring initial compliance with be Quality Manager for system facilities. Facility staff will be re-trained to the use of the new forms once revised and approved. At that point Clinical Supervisor will insure ongoing compliance through random weekly auditing of open charts for the first 30 days.

Compliance date June 1, 2016.

Consent to Release forms do not include verbiage that allows for the verbal revocation of the consent.

The Consents to Release forms have been revised to include the verbiage "This consent may be verbally revoked as well as in writing." Staff have been re-trained and have corrected all current charts as of 4/11/16 having patients resign new Consent forms. Nursing Supervisor will insure ongoing compliance through medical record checks on monthly basis moving forward.

Compliance date April 11, 2016.

imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

Client #2 was admitted on March 31, 2016 and was still an active client at the time of inspection. On a consent form dated 3/31/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to an insurance company thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #3 was admitted on April 2, 2016 and was still an active client at the time of inspection. On a consent form dated 4/2/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to an insurance company thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #4 was admitted on February 20, 2016 and discharged on February 25, 2016. On a consent form dated 2/20/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to an insurance company thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #5 was admitted on January 13, 2016 and discharged on January 18, 2016. On a consent form dated 1/13/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to an insurance company thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #6 was admitted on March 7, 2016 and was still an active client at the time of inspection. On a consent form dated 3/7/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company, thus exceeding the limitations imposed at 4 PA Code 255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #7 was admitted on March 25, 2016 and was still an active client at the time of inspection. On a consent form dated 3/25/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company and government agency, thus exceeding the limitations imposed at 4 PA Code

255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #8 was admitted on March 10, 2016 and was still an active client at the time of inspection. On a consent form dated 3/10/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company and government agency, thus exceeding the limitations imposed at 4 PA Code 255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #9 was admitted on March 19, 2016 and was still an active client at the time of inspection. On a consent form dated 3/19/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company and government agency, thus exceeding the limitations imposed at 4 PA Code 255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #10 was admitted on February 17, 2016 and discharged on March 21, 2016. On a consent form dated 2/17/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company and government agency, thus exceeding the limitations imposed at 4 PA Code 255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #11 was admitted on February 29, 2016 and discharged on March 16, 2016. On a consent form dated 2/29/2016, the facility allowed for the release of the client's alcohol, drug or substance abuse records and mental health records to an insurance company and government agency, thus exceeding the limitations imposed at 4 PA Code 255.5 (b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

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

709.33(a) LICENSURE Notification of Termination

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

Observations

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

Plan of Correction

709.33 Notification of Termination

The facility failed to notify the client, in writing, of a decision to involuntarily terminate a client's treatment.

The findings include:

One client record requiring documentation of a decision to involuntary terminate a client's treatment at the project was reviewed on April 4, 2016. Notification of termination was required in one discharge record reviewed.

Client #12 was admitted on November 30, 2015 and administratively discharged on December 11, 2015. The facility failed to inform the client in writing the decision to involuntarily terminate treatment.

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

POC

Commencing April 14, 2016, all Counselors will be retrained regarding procedures associated with Administrative Discharges. These procedures shall include

1) Meeting with the client and reviewing specific reasons for the involuntary discharge, documenting this on the facility "Notification of Treatment Termination: Administrative Discharge" form. A copy of this form will be given to the client.

2) The counselor will review the Appeal process with the client, and provide this information to the client in writing.

3) The counselor will provide the client with written information regarding other facilities to provide continuing care

4) Counselor will document the session in writing as a Discharge Note

5) Counselor will include information regarding client's Administrative Discharge in the Discharge Summary

6) Counselor will place copies of all forms (Notification of Termination/Appeal process, Available facilities, Discharge Note) in client's record.

Person responsible for implementation and ongoing monitoring is the Clinical Supervisor who will audit 100% of patient charts pending administrative discharge on a monthly basis for a period of 3 months to insure ongoing compliance. POC will be implemented by 4/14/16.

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.

LEHIGH COUNTY CENTER FOR RECOVERY

1620 RIVERSIDE DRIVE
BETHLEHEM, PA 18015

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/13/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 12-13, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the inspection, Lehigh County Center for Recovery 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

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

The patients' records reviewed during the onsite inspection had informed and voluntary consent to release information forms that did not list the purpose of the release of information for patients #10, #12 and did not list the information to be released for patient #13.

Patient #10's informed consent to release information form for a health care provider signed by the patient on 01/13/2017 did not list the purpose of the release.

Patient #12's informed consent to release information form for the funding source for the patient's treatment signed by the patient on 01/02/2017 did not list the purpose of the release.

Patient #13's informed consent to release information form for the patient's family member signed by the patient on 01/30/2017 did not list the information be released.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

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.

Clinical Supervisor responded to deficiency #0276.

Patient #10's informed consent to release information form for a health care provider signed by the patient on 01/13/2017 did not list the purpose of the release. This individual had been discharged at the time of the audit. Therefore the deficiency could not be corrected.

Patient #12's informed consent to release information form for the funding source for the patient's treatment signed by the patient on 01/02/2017 did not list the purpose of the release. This individual had been discharged at the time of the audit. Therefore the deficiency could not be corrected.

Patient #13's informed consent to release information form for the patient's family member signed by the patient on 01/30/2017 did not list the information be released. This individual had been discharged at the time of the audit. Therefore the deficiency could not be corrected.

Commencing May 1, 2017, the Clinical and Nursing Supervisors will retrain employees in their respective departments regarding appropriate completion of all releases. Particular attention will be paid to retraining staff regarding obtaining consent for the purpose for which consent to release is obtained and those items of information to be released.

The above mentioned supervisors will verify that each employee demonstrates understanding and compliance regarding obtaining and recording informed consent for each category of release used in their respective departments.

Effective 5/1/17, the Nurse Manager and Clinical Supervisor will conduct weekly spot checks of that week's admissions, and ensure that all areas of the releases found in the individual's chart have been appropriately completed. Subsequent reviews will be conducted prior to discharge to ensure compliance.

715.9(a)(2) 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: (2) Verify the individual 's identity, including name, address, date of birth, emergency contact and other identifying data.

Observations

Based on a review of facility records conducted during the onsite inspection, the facility failed to verify the identities of four patients who were admitted for narcotic treatment.

Patient #2 was admitted for treatment on 01/18/2017 and was discharged on 01/23/2017.

Patient #3 was admitted for treatment on 01/09/2017 and was discharged on 01/13/2017.

Patient #4 was admitted for treatment on 01/11/2017 and was discharged on 01/15/2017.

Patient #5 was admitted for treatment on 01/16/2017 and was discharged on 01/21/2017.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

715.9(a)(2) LICENSURE (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: (2) verify the individual's identity, including name, address, date of birth, emergency contact and other identifying data.

Commencing June 1, 2017, the Intake coordinator (or nursing after for after hour admissions) will request verification of the individual's identity and other demographic information.

This verification may include:

* Any federal, state or local photo identification card, or legible copy of one (expired are acceptable), the facility will document on the back of any copy the source and/or sender. i.e. driver's license, non-driver license photo ID card, passport, PA citizen identify card, or any other form of photo identification that is provided by a governmental agency which include date of birth. *Student ID will be acceptable if it has the individual's date of birth.

* Unaltered check cashing photo identification Card.

If an individual does not have photo identification: a social security card and one of the following will be accepted:

*Birth Certificate

*Certificate of US citizenship or Consular report of Birth.

*Certificate of Naturalization.

After obtaining the appropriate identification, a photocopy will be made and placed in the individual's record.

The Nurse Manager will be responsible for continued compliance and will monitor the plan through weekly chart audits for a period of 3 months, through August 30, 2017.

Date of completion: June 1, 2017

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.

LEHIGH COUNTY CENTER FOR RECOVERY
1620 RIVERSIDE DRIVE
BETHLEHEM, PA 18015

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/11/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 10-11, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Lehigh County Center for Recovery 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

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

Observations
Based on a review of facility records conducted during the on-site inspection, the facility failed to include all of the required information on its fire drill records.

The fire drill record for the fire drill conducted on 10/22/2017, did not document the number of persons in the building during the time of the drill.

Plan of Correction
All monthly fire drills and emergency drills will be thoroughly documented by the safety manager as to the number of people participating in the drill, number of people in the building, which exit is used, exit time and any unusual encounters. The safety manager will also make note if a smoke alarm or hard wired alarm was used. After each drill is completed the safety manager will document the event in the emergency/fire drill log. The facility director will review the documentation monthly.

These findings were reviewed with facility staff as part of the inspection process.

715.9(a)(2) 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: (2) Verify the individual 's identity, including name, address, date of birth, emergency contact and other identifying data.

Observations
Based on a review of patient records conducted during the on-site inspection, the facility failed to obtain the proper intake documentation for 2 of 3 narcotic treatment patient records reviewed.

Client #1 was admitted for narcotic treatment on 12/12/2017, and was dosed with a narcotic agent on 12/13/2017, but the facility did not obtain an acceptable form of identification for the patient.

Plan of Correction
All clients being admitted into this facility, regardless of level of care, must present upon admission, a state issued ID, passport or a photo ID with address and/or birth date. The admissions coordinator will make a copy of the ID and it will be available for review in the client's chart. Monthly chart checks, by the clinical supervisor , will verify that this process is being done.

Client #3 was admitted for narcotic treatment on 01/09/2018, and was dosed with a narcotic agent on 01/10/2018, but the facility did not obtain an acceptable form of identification for the patient.

These findings were reviewed with facility staff as part of the inspection 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

Based on a review of patient records conducted during the on-site inspection, the facility failed to properly screen patients in 2 of 3 patient records reviewed.

Patient #1 was admitted for narcotic treatment on 12/12/2017, and was dosed with a narcotic agent on 12/13/2017, but the face-to-face determination of whether the individual was currently physiologically dependent upon a narcotic drug was performed by a certified nurse practitioner and not a narcotic treatment physician.

Patient #3 was admitted for narcotic treatment on 01/09/2018, and was dosed with a narcotic agent on 01/10/2018, but the face-to-face determination of whether the individual was currently physiologically dependent upon a narcotic drug was performed by a certified nurse practitioner and not a narcotic treatment physician.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Upon admission for narcotics treatment clients will be thoroughly screened thru a face to face review by the narcotics treatment physician. The narcotic treatment physician shall document in the patients record the basis for the determination of the current dependency and evidence of a one year addiction history.

This will be monitored by the Director of Medicine for the facility.

709.52(b) LICENSURE TX Plan update

709.52. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days.

Observations

Based on a review of facility records conducted during the on-site inspection, the facility failed to document treatment plan updates at least once every 15 days in 4 of 5 applicable client records reviewed. The facility's treatment regimen is less than 30 days.

Client #9 was admitted for treatment on 01/05/2018, and discharged on 1/29/2018. The client's individualized treatment plan was dated 01/08/2018, but the client's

Plan of Correction

Treatment plan updates will be completed at least once every 15 days as per DDAP regulations. This will be initiated by the primary therapist and review by the clinical supervisor for completion. Weekly clinical team meetings will review the treatment plan updates for content and timeliness.

treatment plan was never updated.

Client #10 was admitted for treatment on 12/31/2017, and discharged on 1/28/2018. The client's individualized treatment plan was dated 01/06/2018, but the client's treatment plan was never updated.

Client #12 was admitted for treatment on 12/18/2017, and discharged on 1/15/2018. The client's individualized treatment plan was dated 12/21/2017, but the client's treatment plan was never updated.

Client #13 was admitted for treatment on 11/06/2017, and discharged on 12/20/2017. The client's individualized treatment plan was dated 11/13/2017, but the client's treatment plan was never updated.

These findings were reviewed with facility staff as part of the inspection process.

709.53(a)(10) LICENSURE Discharge Summary

709.53. 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: (10) Discharge summary.

Observations

Based on a review of facility records conducted during the on-site inspection, the facility failed to document complete client records in 2 of 5 applicable records reviewed.

Client #9 was discharged from treatment on 01/29/2018, but there was no discharge summary for the client.

Client #10 was discharged from treatment on 01/28/2018, but there was no discharge summary for the client.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Primary therapists will document the completion of a clients treatment by including a discharge summary for each closed chart.

The clinical supervisor will review and audit each closed chart making sure there is a complete record of the client's treatment history, including but not limited to, the discharge summary.

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.

WHITE DEER RUN OF LANCASTER
53-55 NORTH WEST END AVENUE
LANCASTER, PA 17603

Survey conducted on 03/12/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and buprenorphine monitoring inspection conducted on March 12, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Lancaster 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6.

Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

704.11(c)(3) & (4) LICENSURE Training types and amounts

704.11. Staff development program. (c) General training requirements. (3) At least one-half of all training in this section shall be provided by trainers not directly employed by the project unless the project employs staff persons specifically to provide training for its organization and staff. (4) An individual who holds more than one position in a facility shall meet the training requirement hours set forth for the individual's primary position. Subject areas shall be selected according to the individual's training plan. Primary position is defined as that position for which an individual was hired.

Observations
Based on review of personnel records and the Staffing Requirements Facility Summary (SRFSR) report, the facility failed to ensure that at least one-half of all training was provided by trainers not directly employed by the project in one of four records reviewed.

The findings include:

The SRFSR was reviewed on March 2, 2015 and re-reviewed on March 12, 2015, as well as four personnel records for documentation that at least one-half of all training was provided by trainers not directly employed by the project during the facility's January 1, 2014 to December 31, 2014 training year. The SRFSR and the training certificates located in the personnel file indicated that more than one-half of training completed by employee #3 was provided by trainers directly employed by the project.

Employee #3 was hired as a counselor on June 6, 2011. The SRFSR indicated that employee # 4 received a total of 34 hours of training during the 2014 training year. However, 31.5 hours were provided by facility staff and 2.5 hours were provided by an outside trainer. Upon further review of the personnel file for employee #4 confirmed that the employee did receive 31.5 hours provided by facility staff and 2.5 hours provided by outside trainer.

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

Plan of Correction
One Half of all staff training hours will be provided by trainers not directly employed by the project. Clinical supervisor will ensure this is adhered to. She has been educated on this requirement by QM. The QM department will send out a quarterly report that lists staff and the trainings they have taken. Clinical supervisors will be responsible for assuring that staff have the appropriate type of training hours. The report will be reviewed with counselors in supervisions sessions.

709.28(c) LICENSURE Confidentiality

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

Observations
Based on a review of client records, the facility failed to document a completed informed and voluntary consent from the client prior to the disclosure of information in one of eleven client records.

The findings included:

Eleven client records requiring a completed informed and voluntary consent from the client prior to the disclosure of information were reviewed on March 12, 2015. The facility failed to ensure the documentation of a completed informed and voluntary consent from the client prior to the disclosure of information in client #4's record.

Client #4 was admitted to treatment on February 23, 2015 and was still an active client at the time of the on-site inspection. There was a release of information form to a

Plan of Correction
Consents will be completed in their entirety. Facility Director will re-educate staff on the proper completion of consents. Medical Records Technician will conduct reviews of all admissions for that day to ensure consents are done properly or corrected immediately to prevent violations of confidentiality. Ongoing chart audits by Nurse Manager will be conducted to ensure compliance.

hospital that was signed on 02/23/15, but did not include the specific information to be released. Additionally, there was a second release of information to a pharmacy that was signed on 02/23/15 that did not include the specific information to be released.

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

709.53(a) LICENSURE Complete Client Record

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

Observations

Based on a review of client records, the facility failed to document a complete client record on an individual, which includes documentation of progress notes, aftercare plans, and discharge summaries in five of eleven client records reviewed.

The findings include:

Eleven client records requiring a complete client record on an individual were reviewed on March 12, 2015. The facility did not provide a complete client record for clients # 2, 3, 7, 8, and 9.

Client #2 was admitted to treatment on February 13, 2015 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 02/19/15, 02/20/15, 02/21/15, 02/22/15, 02/23/15, 02/24/15, 02/26/15, 02/27/15, 02/28/15, 03/01/15, 03/02/15, 03/03/15, 03/05/15, 03/07/15, 03/08/15, and 03/09/15 were missing from the client record.

Client #3 was admitted to treatment on February 13, 2015 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 02/14/15, 02/15/15, 02/17/15, 02/18/15, 02/19/15, 02/21/15, 02/22/15, 02/23/15, 02/28/15, 03/01/15, 03/02/15, 03/05/15, 03/06/15, 03/07/15, 03/08/15, and 03/09/15 were missing from the client record.

Client #7 was admitted to treatment on February 02, 2015 and was discharged on March 10, 2015. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 02/13/15, 02/14/15, 02/15/15, 02/16/15, 02/17/15, 02/18/15, 02/19/15, 02/21/15, 02/22/15, 02/23/15, 02/26/15, 02/27/15, 03/01/15, and 03/02/15 were missing from the client record. Additionally, the facility failed to

Plan of Correction

Complete client records will include a progress note for every group documented on the record of service. For those records that are closed, discharge summary and aftercare follow up will be completed and filed. Clinical Supervisor will re-educate clinical staff on the standards for a complete client record. Clinical Supervisor will complete quality review chart audits weekly so that deficiencies can be addressed in a timely manner. Medical Records Technician will review all discharged charts weekly to ensure all paperwork has been filed.

include documentation of an aftercare plan.

Client #8 was admitted to treatment on December 19, 2014 and was discharged on January 12, 2015. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/21/14, 12/22/14, 12/23/14, 12/25/14, 12/26/14, 12/27/14, 12/28/14, 12/30/14, 01/01/15, 01/02/15, 01/03/15, 01/05/15, 01/06/15, 01/07/15, 01/08/15, 01/09/15, 01/10/15, and 01/11/15 were missing from the client record. Additionally, the facility failed to include documentation of a discharge summary.

Client #9 was admitted to treatment on January 27, 2015 and was discharged on February 16, 2015. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 02/01/15, 02/05/15, 02/06/15, 02/07/15, 02/08/15, 02/10/15, 02/11/15, 02/12/15, 02/13/15, 02/14/15, and 02/15/15 were missing from the client record.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN OF LANCASTER

53-55 NORTH WEST END AVENUE
LANCASTER, PA 17603

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 08/12/2015

INITIAL COMMENTS

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

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.

WHITE DEER RUN OF LANCASTER
53-55 NORTH WEST END AVENUE
LANCASTER, PA 17603

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/08/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and inspection conducted for the approval to use a narcotic agent, specifically Buprenorphine, in the treatment of narcotic addiction. This inspection was conducted on March 8, 2016 by staff from the Department of Drug and Alcohol Programs Licensure Division. Based on the findings of the on-site inspection, White Deer Run Inc. - Lancaster, 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)(2) LICENSURE CPR CERTIFICATION

704.11. Staff development program. (c) General training requirements. (2) CPR certification and first aid training shall be provided to a sufficient number of staff persons, so that at least one person trained in these skills is onsite during the project's hours of operation.

Observations

Based on a review of personnel records and CPR/First Aid certification cards, the facility failed to ensure that a sufficient number of staff persons were trained in CPR/First Aid so that at least one person trained in these skills was onsite during the project's hours of operations.

The findings include:

All employee CPR/First Aid certification cards were reviewed on March 8, 2016. A three month work schedule was reviewed and showed several days where staff worked and there was no CPR coverage. The facility is open 24 hours Sunday through Saturday.

The following dates and times reflect a lack of CPR coverage:

12 AM to 8 AM shift

November: 1,7,8,14,15,21,22,28,29

December:
1,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31

January:
1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,25,26,27,28,29,30

Plan of Correction

Program Director will meet with Program Managers and review the standard for having all shifts covered by CPR/First Aid certified employees. Nurse Manager will track all expirations of CPR cards to ensure employees are current. The Region will ensure CPR/First Aid training is offered on a regular basis to employees.

8 AM to 4 PM shift

November: 1,2,4,6,7,8,9,11,12,13,14,15,16,17,18,19,20,21,23,24,25,26,27,28,30

December: 2,3,4,7,8,9,10,11,13,14,15,16,17,18,21,22,23,25,26,27,28,29,30,31

January: 1,2,9,13,20,25,29,

4 PM to 12 AM Shift

November 1,4,5,6,9,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29

December 2,3,5,6,7,12,13,14,19,20,21,26,27

January 1,2,3,4,9,10,11,13,16,17,18,23,24,25,28,29,30

These findings were reviewed with facility staff during the licensing process

705.2 (2) LICENSURE Building exterior and grounds.

705.2. Building exterior and grounds. The residential facility shall: (2) Keep the grounds of the facility clean, safe, sanitary and in good repair at all times for the safety and well-being of residents, employees and visitors. The exterior of the building and the building grounds or yard shall be free of hazards.

Observations

Based on a physical plant inspection, the facility failed to ensure the facility grounds were clean, safe, sanitary and in good repair at all times for the safety and well-being of residents, employees and visitors.

The findings include:

The physical plant inspection occurred on March 8, 2016 at approximately 10:30 am. The second floor landing of the fire escape was obstructed by several layers of cardboard. This presented a fall hazard.

Plan of Correction

Technician Supervisor will ensure fire escape remains free from debris by way of including fire escape in the clinical technicians walk through, every half hour, while they are doing their physical plant checks. Technician Supervisor will review these sheets weekly and reinforce that this is being completed in ongoing technician meetings monthly.

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

705.10 (c) (4) LICENSURE Fire safety.

705.10. Fire safety. (c) Fire extinguisher. The residential facility shall: (4) Instruct all staff in the use of the fire extinguishers 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 a fire extinguisher upon staff employment for one of four personnel records reviewed.

The findings include:

Four personnel records were reviewed on March 8, 2016. The facility failed to document that the fire extinguisher training was completed upon employment for employee #4.

Plan of Correction

Technician Supervisor will ensure all new hire employees will be instructed in fire safety, including the use of fire extinguishers, within their first three (3)days of emplyment. Certificate of Training will be filed in employee HR file.

Employee # 4 was hired on November 30, 2015. Fire extinguisher training was due to be completed no later than December 7, 2015. The facility did not document the completion of fire extinguisher training until February 2, 2016.

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

705.10 (d) (3) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential 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 are trained to perform assigned tasks during emergencies in one of four personnel records reviewed.

The findings include:

Four personnel records were reviewed on March 8, 2016. The facility failed to document that the emergency training was completed for employee, # 4.

Employee # 4 was hired on November 30, 2015. Emergency training was due to be completed no later than December 7, 2015. The facility did not document the completion of emergency training until February 2, 2016.

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

Plan of Correction

Technician Supervisor will ensure all new hire employees recieve the Fire and Safety Training, including what to do in an emergency situation, within their first three (3) days of employment. Certificate of Training will be filed in employee HR file.

705.10 (d) (4) LICENSURE Fire safety.

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

Observations

Based on a review of the fire drill logs, the facility failed to conduct unannounced fire drills at least once per month as required by regulation.

The findings include:

The fire drill logs were reviewed on March 8, 2016 from the date of the last inspection, March 2, 2015. Fire drills were required from the month of April 2015 until February 2016. There was no documentation of unannounced fire drills for the months of April 2015, June 2015, July 2015, August 2015, September 2015, November 2015, December 2015, and January 2016.

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

Plan of Correction

Technician Supervisor has updated the facility Physical Plant and Fire Safety Manual to include monthly fire drill records. Technician Supervisor will train new technicians and ensure unannounced fire drills will be documented every month. Program Director will review the manual monthly over the next quarter,to confirm these are being completed.

709.28 (c) (1) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record in seven of ten client records.

The findings include:

Ten client records were reviewed on March 8, 2016 for informed and voluntary consent to release client information. The facility failed to obtain or document an informed and voluntary consent to release in client records # 1, 2, 3, 4, 7, 8 and 9.

Client #1 was admitted on February 21, 2016 and was still an active client at the time of inspection. A consent form dated 2/16/16 allowed for the release of the clients alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to an insurance company. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent form in writing.

Client #2 was admitted on February 12, 2016 and was still an active client at the time of inspection. A consent form dated 2/5/16 allowed for the release of the clients alcohol, drug, or substance abuse records to probation. In addition the facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Client #3 was admitted on February 20, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Client #4 was admitted on February 19, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Client #7 was admitted on March 4, 2016 and discharged on March 8, 2016. A consent form dated 3/4/16 allowed for the release of the clients alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to an insurance company and government agency. In addition the facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Client #8 was admitted on March 6, 2016 and was still an active client at the time of inspection. A consent form dated 3/6/16 allowed for the release of the clients alcohol, drug, or substance abuse records, HIV testing and results, and mental health records to an insurance company. In addition the facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Plan of Correction

Nurse Manager provided a training 3/17/2016 on the proper documentation for the Release of Information on the consents. An additional line has been added to consents indicating the consent can be revoked verbally. All current clients resigned new consents as of 4/10/16. Nurse Manager will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct. Quality Manager is working with corporate to make changes to the consent document which will permanently address the issue.

Client #9 was admitted on February 15, 2016 was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

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

709.52(c) LICENSURE Provision of Counseling Services

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

Observations

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

The findings include:

Nine client records were reviewed for counseling services during the renewal inspection on March 8, 2016. The project failed to ensure that clients received counseling services according to the client's individual treatment and rehabilitation plan in client records # 2, 5, and 6.

Client # 2 was admitted to the facility on February 12, 2016 and was still an active client at the time of inspection. Client #2's record contained a treatment plan dated 2/15/16 that identified the counseling services to be provided as individual therapy twice per week and group therapy four times per week. The record did not contain documentation of any individual therapy sessions from 2/26/2016 - 3/7/2016.

Client # 5 was admitted to the facility on February 20, 2016 and was still an active client at the time of inspection. Client #5's record contained a treatment plan dated 2/23/16 that identified the counseling services to be provided as individual therapy once per week and group therapy four times per week. The record did not contain documentation of any individual therapy sessions for the week of 2/28/2016-3/06/2016.

Client # 6 was admitted to the facility on February 19, 2016 and was still an active client at the time of inspection. Client #6's record contained a treatment plan dated 2/24/16 that identified the counseling services to be provided as individual therapy once per week and group therapy four times per week. The record did not contain documentation of any individual therapy sessions for the week of 2/27/16-3/5/2016.

These findings were reviewed with facility staff during the licensing process

Plan of Correction

Clinical Supervisor provided training to counselors regarding the standards and documentaiton of individual sessions on 3/28/2016. Clinical Supervisor will check to make sure DAP Note, and Record of Service match what is indicated on the Client Treatment Plan. Minimum standard of one individual per week will be met.

Clinical Supervisor will monitor compliance through monthly chart reiews and supervisions.

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.

WHITE DEER RUN OF LANCASTER
53-55 NORTH WEST END AVENUE
LANCASTER, PA 17603

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 05/25/2016

INITIAL COMMENTS

This report is a result of a supervisory review of the written report of the findings of an on-site licensure inspection that was conducted on March 8, 2016, by staff from the Division of Drug and Alcohol Program Licensure. Based on the supervisory review of findings from the on-site inspection, White Deer Run Inc. - Lancaster, 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 supervisory review:

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

The facility failed to ensure that counseling staff completed the 4 hours of tuberculosis, sexually transmitted diseases training within the first year of employment.

Employee #5 was hired as a counselor on September 8, 2014 and did not complete the required training by the date of the licensing inspection.

Plan of Correction

Compliance will be monitored during required supervisions sessions with all new clinical staff by Clinical Supervisor to ensure mandated training is completed within the first year of employment with the facility.

Clinical Supervisor has signed counselor up for the next available 4 hour tuberculosis, sexually transmitted disease training on 7/20/16 and submited verification of registration to Program Director.

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.

WHITE DEER RUN OF LANCASTER
53-55 NORTH WEST END AVENUE
LANCASTER, PA 17603

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/14/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and buprenorphine monitoring inspection. The inspection was conducted on April 12- 14, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, White Deer Run of Lancaster was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

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

The facility failed to document a written involuntary termination notice in two of two client records.

Nine client records were reviewed on April 12-14, 2017. Two of the clients reviewed were involuntarily terminated from treatment at the project. Client records #7 and 9 did not include documentation of a written involuntary termination notice.

Client #7 was admitted on 2/25/27 and terminated on 3/13/17. There was no written involuntary termination notice in client record #7.

Client #9 was admitted on 12/11/16 and terminated on 12/30/16. There was no written involuntary termination notice in client record #9.

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

Plan of Correction

Any individual that is administratively discharged from the program will receive a copy of this form either in person or via mail 100% of the time. All clinical staff was instructed on the proper use of the form April 17th by the program director. The clinical supervisor will ensure through supervision that the individual counselor will fill out and explain the form at the time a decision is made to administratively discharge the individual.

709.52(d) LICENSURE Regularity of counseling provided

709.52. Treatment and rehabilitation services. (d) Counseling shall be provided to a client on a regular and scheduled basis.

Observations

The facility failed to document that counseling was provided to clients on a regular and scheduled basis.

Nine client records were reviewed on April 12-14, 2017. Client records #5, 6 and 7 did not include documentation that counseling was provided on a regular and scheduled basis.

Client #5 was admitted on March 20, 2017. There were progress notes documented for March 29, March 30 and April 6; however, these sessions were not documented on the record of service. There were no entries on the record of service for the time period of 3/26/17 - 4/10/17.

Client #6 was admitted on March 29, 2017. There were no progress notes or entries on the record of service from 4/4/17 - 4/10/17.

Client #7 was admitted on February 25, 2017 and discharged on March 13, 2017. There were no progress notes or entries on the record of service for the time period of 3/9/17 - 3/13/17.

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

Plan of Correction

The clinical supervisor will ensure that all group and individual notes will be completed and filed in individual records 24 hours after the group or individual session is completed. The clinical supervisor will conduct ongoing open chart audits on a weekly basis to ensure the notes are in place and coincide with the record of service.

709.53(a) LICENSURE Complete Client Record

709.53. 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

The facility failed to document a complete client record including records of service, progress notes and/or follow up in 6 of 6 inpatient client records.

Six inpatient client records were reviewed on April 12-14, 2017. Client records #1, 5, 6, 7, 8 and 9 did not include documentation of a record of service, progress notes and/or follow up.

Client #1 was admitted on March 18, 2017. According to the record of service, group sessions were completed on April 3, April 4 and April 10; however, there were no corresponding progress notes for those services.

Plan of Correction

The clinical supervisor will ensure through ongoing weekly open chart audits that all components of the client record, including group/individual progress notes will coincide with the record of service and completed within 24 hours. Follow-up calls will be conducted by the case manager within seven days of discharge appropriately documented on the form. The clinical supervisor will ensure 100% compliance through closed chart audits.

Client #5 was admitted on March 20, 2017. There were progress notes documented for March 29, March 30 and April 6; however, these sessions were not documented on the record of service. There were no entries on the record of service for the time period of 3/26/17 - 4/10/17.

Client #6 was admitted on March 29, 2017. There were no progress notes or entries on the record of service from 4/4/17 - 4/10/17.

Client #7 was admitted on February 25, 2017 and discharged on March 13, 2017. There was a progress note for a group session on 2/27/17; however this session was not on the record of service. There were no progress notes or entries on the record of service for the time period of 3/9/17 - 3/13/17.

Client #8 was admitted on September 14, 2016 and discharged on October 13, 2016. There were entries on the record of service for 10/11 and 10/12/16; however, there were no corresponding progress notes. There was also no follow up contact for client #8.

Client #9 was admitted on December 11, 2016 and discharged on December 30, 2016. There was no follow up contact documented for client #9.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN OF HARRISBURG
GOVERNOR'S PLAZA SOUTH, 2001 NORTH FRONT STREET
Building 1, Suite 212-217
HARRISBURG, PA 17102

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/17/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 17, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Harrisburg 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction
The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

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

Observations
Based on a review of client records, the facility failed to

Plan of Correction
Clinical Director will complete an in-service training with

notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project, in one of four client records.

The findings include:

Four client records requiring documentation that the client was notified in writing of the facility's decision to involuntarily terminate treatment at the project were reviewed on March 17, 2015. The facility failed to notify the client, in writing, of a decision to involuntarily terminate treatment at the project, in client record # 4.

Client #4 was admitted on September 4, 2014 and discharged on November 3, 2014. There was no documentation that a termination letter was completed when the client was administratively discharged due to medical reasons on November 3, 2014.

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

clinical staff on 4/24/15 to assure understanding of this standard. Clinical Director will conduct monthly chart audits as well as monthly and/or quarterly supervision of clinical staff to assure ongoing compliance of this standard. Clinical Supervisor will address during monthly individual supervisions with each counselor any deficiencies in this area and develop an individual development plan identifying areas to be improved upon in regard to documentation for client records. Clinical Supervisor will be responsible for assuring all documentation is completed and filed in client's records.

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 provide a complete client record on each individual which included information relative to the client's involvement with the project in four of ten client records.

The findings include:

Ten client records were reviewed on March 17, 2015. The facility failed to provide a complete client record on each individual which included information relative to the client's involvement with the project in client records #2, 7, 8, and 10.

Client #2 was admitted on May 22, 2014 and was still an active client at the time of the inspection. The Record of Services indicated that the client attended treatment on January 15, 2015. There was no documentation of a treatment note for that session.

Client #7 was admitted on February 19, 2014 and discharged on January 1, 2015. The Record of Services indicated that the client attended treatment on July 30, 2014 and January 5, 2015. There was no documentation of a treatment note for either session. In addition, the facility failed to document

Plan of Correction

Clinical Director will complete an in-service training with clinical staff on 4/24/15 to assure understanding of this standard. Clinical Director will conduct monthly chart audits as well as monthly and/or quarterly supervision of clinical staff to assure ongoing compliance of this standard. Clinical Supervisor will address during monthly individual supervisions with each counselor any deficiencies in this area and develop an individual development plan identifying areas to be improved upon in regard to documentation for client records. Clinical Supervisor will be responsible for assuring all documentation is completed and filed in client's records.

the completion of a case consultation on August 19, 2014 and November 19, 2014.

Client #8 was admitted on March 3, 2014 and discharged on December 29, 2014. The facility failed to document the completion of a case consultation on September 3, 2014. In addition, a discharge summary was due by January 5, 2015. The facility failed to document the completion of a discharge summary.

Client #10 was admitted on April 8, 2014 and discharged on July 17, 2014. The Record of Services indicated that the client attended treatment on July 7, 2014. There was no documentation of a treatment note for that session.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN OF HARRISBURG
GOVERNOR'S PLAZA SOUTH, 2001 NORTH FRONT STREET
Building 1, Suite 212-217
HARRISBURG, PA 17102

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/16/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 16, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Harrisburg, 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

709.28(a)(1) LICENSURE Confidentiality
709.28. Confidentiality. (a) A written procedure shall be developed by the project director which shall comply with 4 Pa. Code 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure shall include, but not be limited to: (1) Confidentiality of client identity and records.

Observations
Based on a review of the project's consent to release, the facility failed to inform clients of their right to verbally revoke a consent to release of information in four of nineteen client records.

The findings include:

Nineteen client records were reviewed on March 16, 2016. The "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

Client #8 was admitted on 12/17/15 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #17 was admitted 1/15/16 and discharged on 2/15/16. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Plan of Correction
Clinical Director provided a training 4/18/16 on the proper documentation for the Release of Information on the consents. An additional line has been added to consents indicating the consent can be revoked verbally. All current clients will resign new consents starting 4/18/16 and be completed by 4/29/16. Clinical Director will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct. Quality Manager is working with corporate to make changes to the consent document which will permanently address the issue.

Client #18 was admitted on 1/5/16 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #19 was admitted on 1/12/16 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

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

709.33(a) LICENSURE Notification of Termination

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

Observations

Based on a review of client records, the facility failed to inform the client, in writing, of a decision to involuntarily terminate the client's treatment in three of nineteen client records reviewed.

Plan of Correction

A former staff person was responsible for the deficiencies noted. Clinical supervisor reviewed with the current staff the policy that notification of termination must be sent to the client upon discharge at the staff meeting in on 3/24/16. Clinical supervisor will monitor adherence to policy through monthly chart reviews and supervision.

The findings include:

Five client records requiring a termination letter were reviewed on March 16, 2016. The facility failed to document a notice of termination in client records #11, 13, and 16.

Client #11 was admitted to the facility on August 21, 2015 and was administratively discharge on November 5, 2015. The facility failed to inform the client in writing the decision to involuntarily terminate treatment.

Client #13 was admitted to the facility on March 25, 2015 and was administratively discharge on November 25, 2015. The facility failed to inform the client in writing the decision to involuntarily terminate treatment.

Client #16 was admitted to the facility on December 4, 2015 and was administratively discharge on March 1, 2016. The facility failed to inform the client in writing the decision to involuntarily terminate treatment.

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

709.92(a) LICENSURE Treatment and rehabilitation services

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

Observations

Based on a review of client records, the facility failed to

Plan of Correction

Clinical supervisor reviewed with the current staff the policy

document an individual treatment and rehabilitation plan that was developed with the client in six of nineteen outpatient activity client records.

The findings include:

Nineteen outpatient activity client records were reviewed on March 16, 2016. All were reviewed for individualized treatment and rehabilitation plans which are to be developed with the client. Client records # 4, 7, 11, 15, 18, and 19 did not contain an individualized treatment and rehabilitation plan that was developed with the client.

Client #4 was admitted to the facility on March 24, 2015 and their individualized treatment and rehabilitation plan was developed on March 31, 2015. The treatment plan was not signed by the client until July 21, 2015.

Client #7 was admitted to the facility on September 14, 2015 and their individualized treatment and rehabilitation plan was developed on September 15, 2015. The treatment plan was not signed by the client until January 14, 2016.

Client #11 was admitted to the facility on August 21, 2015 and their individualized treatment and rehabilitation plan indicated that it was developed on January 28, 2015. The treatment plan was not signed by the client until August 25, 2015, but was signed by the counselor on August 21, 2015.

Client #15 was admitted to the facility on September 14, 2015 and their individualized treatment and rehabilitation plan indicated that it was developed September 15, 2015. The treatment plan was not signed by the client or counselor until October 6, 2015.

Client #18 was admitted to the facility on January 5, 2016 and their individualized treatment and rehabilitation plan was developed January 18, 2016. The treatment plan was not signed by the client until January 21, 2016.

Client #19 was admitted to the facility on January 12, 2016 and their individualized treatment and rehabilitation plan was developed January 26, 2016. The treatment plan was not signed by the client until January 27, 2016.

These findings were reviewed with facility staff during the

that an individualized plan must be established with the client within 14 days of admission at the staff meeting on 3/24/16. Clinical supervisor will monitor adherence to policy through monthly chart reviews and supervision.

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 client records, the facility failed to document a physician signature on the individual treatment and rehabilitation plans for medical assistance clients which is required by the Office of Medical Assistance in two of seven client records.

The findings included:

Nineteen client records were reviewed on March 16, 2016. Two of seven client records were required to have a physician signature on the individual treatment plans. The individual treatment plans contained in client records #10 and #17 did not contain a physician signature which is required by the Office of Medical Assistance.

Client #10 was admitted to outpatient treatment on September 16, 2015. The individual treatment and rehabilitation plan was developed on September 22, 2015, and did not include a physician signature.

Client #17 was admitted to outpatient treatment on January 15, 2016. The individual treatment and rehabilitation plan was developed on January 29, 2016, and did not include a physician signature.

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

Plan of Correction

Plan of Correction:

Clinical supervisor reviewed with the current staff the policy that all clients with medical assistance pay source must have their records signed by the physician within 14 days of admission at the staff meeting in on 3/24/16. Clinical supervisor will monitor adherence to policy through monthly chart reviews and supervision.

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.

WHITE DEER RUN OF HARRISBURG

GOVERNOR'S PLAZA SOUTH, 2001 NORTH FRONT STREET
Building 1, Suite 212-217
HARRISBURG, PA 17102

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/05/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 5, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Harrisburg 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 inspection and 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.

WHITE DEER RUN OF HARRISBURG
GOVERNOR'S PLAZA SOUTH, 2001 NORTH FRONT STREET
Building 1, Suite 212-217
HARRISBURG, PA 17102

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/17/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 17, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of harrisburg 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

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

Observations
The facility failed to document a psychosocial evaluation in four of seven client records reviewed on March 17, 2018.

Client records # 2, 3, 5 and 6 were missing documentation of a psychosocial evaluation.

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

Plan of Correction
All staff are being trained on completing an evaluative summary for each chart upon completion of assessment and development of master treatment plan. All staff will be trained on May 17, 2018

Clinical Supervisor will monitor with monthly chart reviews.

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
The facility failed to document an individual treatment and rehabilitation plan in two of seven client records reviewed on April 17, 2018.

Client records # 2 and 3 were missing documentation of an individual treatment plan.

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

Plan of Correction
Clinical Supervisor will monitor on a monthly basis that clinicians will have developed, documented and filed master treatment plans for all clients engaged in services. Clinicians will be trained and have developed a master treatment plan by the 14th day of treatment of clients in services. Training will occur on May 17, 2018.

709.93(a)(5) 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: (5) Progress notes.

Observations

The facility failed to document progress notes for counseling sessions documented on the record of service in three of seven records reviewed on April 17, 2018.

The record of service documents kept counseling appointments that are verified by the signature of both the counselor and client.

Client # 2 had counseling sessions documented on the record of service for 12/8, 12/11, 12/13, 12/19, 12/22 and 12/28, 2017. 1/17, 1/24, 1/31, 2/5, 3/1, 3/13, 3/23 and 4/3, 2018. There were no progress notes documented for these dates.

Client # 3 had counseling sessions documented on the record of service for 2/14, 2/23, 2/26, 2/27, 2/28, 3/2, 3/7, 3/12, 3/14, 3/16, 3/19, 3/23, 3/26, 3/28, 3/30, 4/2, 4/4, 4/6 and 4/12, 2018. There were no progress notes documented for these dates.

Client # 6 had counseling sessions documented on the record of service for 9/8, 9/28 and 11/16, 2017. There were no progress notes documented for these dates.

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

Plan of Correction

All staff are being trained to complete and file all progress notes for groups and individual sessions within 3 business days of the clients appointments. Training occurred on April 30, 2018.

Clinical Supervisor will monitor with monthly chart reviews.

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.

WHITE DEER RUN, INC.
1921 WEST 8TH STREET
ERIE, PA 16505

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 conducted on March 24, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection.

Plan of Correction

704.6(a) LICENSURE Clinical Supervisor Qualifications

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

Observations

Based on a review of the Staffing Requirements Facility Summary Report forms for all of the facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

Completion date July 1, 2015.

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.

WHITE DEER RUN, INC.

1921 WEST 8TH STREET
ERIE, PA 16505

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/17/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal inspection conducted on March 17, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, White Deer Run, 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 inspection and 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.

WHITE DEER RUN, INC.
1921 WEST 8TH STREET
ERIE, PA 16505

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/13/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 13, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, 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	**Plan of Correction**
The facility failed to document 6 hours of HIV/AIDS training in one of one personnel record reviewed during the onsite licensing inspection conducted on April 13, 2017.	Clinical Director will monitor staff trainings on a quartely basis to ensure staff complete HIV/AIDS training within the appropriate time period.
Employee # 5 is support staff and was hired on April 14, 2014.	Employee has identified a 6hour HIV/AIDS training and is registered to attend Basic HIV on May 9, 2017.
The findings were reviewed with facility staff during the licensing process.	Clinical director will provide proof of trainings and send certificate of completions to Cove Forge Training Department.

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	**Plan of Correction**
The facility failed to obtain an informed and voluntary consent from the client for the disclosure of information in nine of nine client records reviewed during the annual licensing inspection conducted on April 13, 2017.	Clinical Director corrected this and a QSOA was obtained 4-18-17.
Urine samples were sent to a laboratory for analysis during the intake process and at random times throughout treatment without the client's written consent or a Qualified Service Organization Agreement (QSOA) in the following client records:	Clinical Director will ensure that if lab changes in the future a new QSOA will be obtained or client's will sign a consent to release information.

Client # 1 was admitted January 18, 2017 and discharged on March 16, 2017.

Client # 2 was admitted June 28, 2016 and discharged on January 30, 2017.

Client # 3 was admitted November 10, 2016 and discharged on March 13, 2017.

Client # 4 was admitted September 13, 2016 and discharged on February 3, 2017.

Client # 5 was admitted January 19, 2017 and discharged on February 28, 2017.

Client # 6 was admitted July 13, 2016 and discharged on October 31, 2016.

Client # 7 was admitted September 14, 2016.

Client # 8 was admitted November 25, 2016.

Client # 9 was admitted January 4, 2017.

The findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN, INC.
1921 WEST 8TH STREET
ERIE, PA 16505

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 05/02/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on May 2, 2018 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, White Deer Run, 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
The facility failed to document TB/STD training in one of one personnel record reviewed on May 2, 2018.

Plan of Correction
Counselor/ Employee #3 is scheduled for TB/STD training through DDAP on June 14, 2018.

Employee # 3 was hired as a counselor in December 2016. TB/STD training was to be completed by December 2017. There was no documentation provided that the employee had completed the training.

In the future, Clinical Director will be responsible for making sure staff complete all required trainings for the first year of employment.

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

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.

WHITE DEER RUN AT BLUE MOUNTAIN
8284 LEASER ROAD
KEMPTON, PA 19529

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/16/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 16, 2015 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, White Deer Run At Blue Mountain 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

Completion date July 1, 2015.

709.53(a) LICENSURE Complete Client Record

709.53. 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

Plan of Correction

Each client will have a record of service initiated by the

document a complete client record on an individual, which includes documentation of complete and accurate records of service, as well as follow-up information in five of eleven client records reviewed.

The findings include:

Eleven client records requiring a complete client record on an individual were reviewed on March 16, 2015. The facility did not provide a complete client record for clients # 3, 4, 5, 8, and 10.

Client #3 was admitted to treatment on February 19, 2015 and was still an active client at the time of the on-site inspection. A 02/20/2015 group progress note, a 03/06/2015 group progress note and a 02/25/2015 individual progress note were included in the chart; however, the services were absent from the record of service. Therefore, the facility failed to accurately document the record of service.

Client #4 was admitted to treatment on February 25, 2015 and was still an active client at the time of the on-site inspection. A 03/06/2015 group progress note, a 03/03/2015 individual progress note and a 003/09/2015 individual progress note were included in the chart; however, the services were absent from the record of service. Therefore, the facility failed to accurately document the record of service.

Client #5 was admitted to treatment on February 25, 2015 and was still an active client at the time of the on-site inspection. A 03/06/2015 group progress note, a 03/03/2015 individual progress note and a 03/11/2015 individual progress note were included in the chart; however, the services were absent from the record of service. Therefore, the facility failed to accurately document the record of service.

Client #8 was admitted to treatment on September 23, 2014 and was discharged on October 15, 2014. A 10/05/2014 group progress note, a 10/09/2014 individual progress note and a 10/14/2014 individual progress note were included in the chart; however, the services were absent from the record of service. Therefore, the facility failed to accurately document the record of service. Additionally, there was no documentation of any follow-up information in the client chart at the time of the inspection.

Client #10 was admitted to treatment on October 13, 2014 and was discharged on October 24, 2014. A 10/17/2014 group progress note, and a 10/22/2014 individual progress note were included in the chart; however, the services were absent from the record of service. Therefore, the facility

Clinical Supervisor upon admission, and placed in a binder. The record of service will be dated to reflect initial contact with a counselor and any and all encounters thereafter starting April 1, 2015. To ensure there are no undocumented visits, the record of service will be physically taken to morning and afternoon shift reports and handed to each clinician individually. They will document on each and every client they had contact with that day. In addition, the Clinical Supervisor will reference the record of service during group supervision weekly, to ensure accountability and completeness.

The Clinical Supervisor and Campus Director will verify completeness of the record of service daily at morning and afternoon shift report, and return to clinician if incomplete.

Completion date May 1, 2015

failed to accurately document the record of service. Additionally, there was no documentation of any follow-up information in the client chart at the time of the inspection.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN AT BLUE MOUNTAIN

8284 LEASER ROAD
KEMPTON, PA 19529

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 08/12/2015

INITIAL COMMENTS

This report is a result of an on-site Unusual Incident investigation conducted on August 12, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, White Deer Run at Blue Mountain 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

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.

WHITE DEER RUN AT BLUE MOUNTAIN
8284 LEASER ROAD
KEMPTON, PA 19529

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/21/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 21, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, at Blue Mountain 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 personnel records, the facility failed to provide documentation of TB/STD training in one of four personnel records reviewed.

The findings include:

Four personnel records were reviewed on March 21, 2016 for documentation of HIV/AIDS and TB/STD training. The facility did not provide documentation of the required TB/STD training in personnel record # 2.

Employee # 2, a counselor, was hired January 21, 2015. HIV/AIDS and TB/STD training was due to be completed no later than January 21, 2016. The facility failed to provide documentation of TB/STD training as of the date of this inspection.

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

Plan of Correction

Counselor produced certficate for TB/STD training after the close of business on March 21, 2016 to the Progrma Director.

Counselor had completed 4 hours of STD/TB/Hepatitis Training approved by PA Department of Health on April 23, 2007, trained by DDAP.

The facility failed to have the Counselor produce this certificate of training upon hire, therefore it was not included in his training file.

In the future the Program Director will ask all seasoned employees for their training certificates and follow-up immediately to have them attend any missing DDAP required trainings so as not to miss training deadlines.

705.2 (2) LICENSURE Building exterior and grounds.

705.2. Building exterior and grounds. The residential facility shall: (2) Keep the grounds of the facility clean, safe, sanitary and in good repair at all times for the safety and well-being of residents, employees and visitors. The exterior of the building and the building grounds or yard shall be free of hazards.

Observations

Based on an observation during the physical plant inspection, it was determined that the project failed to maintain all structures on the grounds of the facility so as to be free from any danger to health or safety in two of the seven inpatient residential rooms.

The findings were:

During the physical plant inspection conducted on March 21, 2016 at approximately 10:00 am, it was observed that on the 1st floor of the residential rooms in Room D, there was a baseboard radiator/heater that was broken with sharp edges exposed, which poses a safety risk. Additionally, in Room B on the 1st floor of the residential rooms, there was a small hole in the wall with dry wall and paint peeling off surrounding it above the 2nd bed to the right of the room.

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

Plan of Correction

The panel on the front of the heating unit was off the hook which exposed the fins or interior of the heating unit. This panel can be easily removed for cleaning purposes, and on this date was off of the hook. Once the panel was replaced, there were no sharp internal or external parts/pieces exposed.

These panels will be checked routinely on a daily basis by the housekeeper to ensure there are no components exposed causing a safety issue. In addition, they will all be checked weekly during leadership rounds where either the Program Director or Facility Services Coordinator will ensure their integrity.

The integrity of the drywall has been compromised by individuals picking and pulling at the wall. The hole/area above the bed will be sanded down and repainted by April 12, 2016.

709.28 (c) (1) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent to release in four of eight client records.

The findings include:

Based on a review of these records, the facility's consent to release client information was observed to be out of compliance with 42 CFR and State Law 4 Pa Code 255.5(b).

The "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing.

Eight client records were reviewed on March 21, 2016 for informed and voluntary consent to release client information forms. The facility failed to obtain or document an informed

Plan of Correction

Facility Director will provide training to all staff prior to 4/18/2016 on proper documentation for the release of information on consents. In accordance with 42 CFR and State Law 4 Pa Code 255.5(b), an additional line has been added to the existing consents indicating the consent may be revoked verbally. All current clients will resign these new consents by 4/18/16. Facility Director and Clinical Supervisor will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct. Quality Manager is working with corporate to make changes to the consent document which will permanently address the issue.

and voluntary consent to release client identifying information in client records # 1, 2, 7, and 8.

Client #1 was admitted on February 27, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

Client #2 was admitted on March 1, 2016 and was still an active client at the time of inspection. On a consent form dated 3/01/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records to probation and an insurance company thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #7 was admitted on January 12, 2016 and discharged on January 21, 2016. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

Client #8 was admitted on December 23, 2015 and discharged on January 21, 2016. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

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

709.53(a)(5) LICENSURE Progress Notes

709.53. 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: (5) Progress notes.

Observations

Based on the review of client records, the facility failed to document clinical progress notes in four of eight client records.

The findings include:

Eight client records were reviewed on March 21, 2016. There was no documentation of clinical progress notes in patient records # 2, 4, 5, and 6.

Client #2 was admitted to treatment on March 1, 2016 and was still an active client at the time of inspection. According to the record of service a session took place on 3/21/2016 but there was no corresponding progress note in clients record at the time of review.

Client #4 was admitted to treatment on October 2, 2015 and was discharged on Ocotber 29, 2015. According to the record of service sessions took place on 10/9/2015 and 10/21/2015 but there were no corresponding progress notes in clients

Plan of Correction

The Clinical Supervisor will review the record of service on a daily basis to ensure that all counselors are documenting groups and individual sessions.

Weekly on a Friday, the clinical supervisor will do open chart audits to ensure that all charts contain daily group notes and weekly individual notes for that particular week.

The clinical supervisor will follow-up with the counselor during weekly supervision if he finds any group or individual progress notes missing.

This process began on March 22, 2016.

record at the time of review.

Client #5 was admitted to treatment on October 23, 2015 and was discharged on November 13, 2015. According to the record of service an individual session took place on 10/26/2015 and 11/05/2015 but there were no corresponding progress notes in clients record at the time of review.

Client #6 was admitted to treatment on December 7, 2015 and was discharged on January 4, 2016. According to the record of service sessions took place on 12/16/2015, 12/18/2015 and 12/23/2015 but there were no corresponding progress notes in clients record at the time of review.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN AT BLUE MOUNTAIN
8284 LEASER ROAD
KEMPTON, PA 19529

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/18/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 18, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Lehigh County Center for Recovery 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

709.33 (a) LICENSURE Notification of termination.

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

Observations
Based on a review of facility records conducted during the onsite inspection the facility failed to give proper notification when involuntarily discharging clients in 1 of 1 applicable records reviewed.Client #2 was involuntarily discharged on 11/17/2017, but there is no documentation that the client was notified in writing for the reason for his or her involuntary discharge.These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
All clinical staff was instructed on April 17th by the Program Director regarding the proper use of the administrative discharge form. Individuals that are administratively discharged from the program will be notified in writing 100% of the time by their primary counselor. The clinical supervisor will ensure through ongoing supervision that the individual counselor understands the purpose completes the form at the time a decision is made to administratively discharge the individual. In addition, the clinical supervisor will ensure the form was completed and the individual was given a copy either in person or by email through monthly chart audits.

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.

WHITE DEER RUN AT BLUE MOUNTAIN
8284 LEASER ROAD
KEMPTON, PA 19529

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/16/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 16, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run at Blue Mountain 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

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

Observations
Based on the physical plant inspection the facility failed to ensure that the hot water in the bathrooms remained lower than 120 degrees Fahrenheit. The hot water temperature for G Room on the second floor was tested at 140 degrees Fahrenheit. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
Water temperature was immediately turned down on main boiler system and set at 110 degrees. Water was then tested to reflect water temperature at 112 degrees.

Facility services manager will check temperature setting on boiler,test the temperature of the water and record the findings weekly during Leadership rounds for 90 days commencing April 20, 2018. After the completion of the 90 day monitoring, testing will be conducted monthly to ensure ongoing consistent temperature readings.

709.28 (c) (3) LICENSURE Confidentiality
§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (3) Purpose of disclosure.

Observations
Based on a review of client records conducted during the on-site inspection, the facility failed to include all of the required information on its signed consent to release information forms in 1 of 6 records reviewed. Client #3 was admitted for treatment on 2/06/2018. The client's consent to release information for domestic relations did not list the purpose of the release. These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
Consent training conducted to all staff on April 18, 2018 by Facility Director to include attention to all areas of the consent needing to be filled out completely to ensure completeness.

Open chart audits were completed on 3 individual charts on April 17, 2018. All 3 charts were found to be in compliance. Open chart audits will be conducted by the Clinical Supervisor on a weekly basis and ongoing, paying close attention to validation of consents and marked off as completed.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 02/05/2015

INITIAL COMMENTS

This report is a result of an unusual incident investigation conducted on February 5, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the investigation, the unusual incident at White Deer Run-Allenwood were unable to be substantiated. Therefore, no deficiencies were identified during this investigation and 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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/04/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on March3, 2015 through March 4, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.6(a) LICENSURE Clinical Supervisor Qualifications

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

Observations

Based on a review of the Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

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

704.11. Staff development program. (f) Training requirements for counselors. (2) Each counselor shall complete at least 25 clock hours of training annually in areas such as: (i) Client recordkeeping. (ii) Confidentiality. (iii) Pharmacology. (iv) Treatment planning. (v) Counseling techniques. (vi) Drug and alcohol assessment. (vii) Codependency. (viii) Adult Children

of Alcoholics (ACOA) issues. (ix) Disease of addiction. (x) Aftercare planning. (xi) Principles of Alcoholics Anonymous and Narcotics Anonymous. (xii) Ethics. (xiii) Substance abuse trends. (xiv) Interaction of addiction and mental illness. (xv) Cultural awareness. (xvi) Sexual harassment. (xvii) Developmental psychology. (xviii) Relapse prevention. (3) If a counselor has been designated as lead counselor supervising other counselors, the training shall include courses appropriate to the functions of this position and a Department approved core curriculum or comparable training in supervision.

Observations

Based on a review of the Staffing Requirements Facility Summary Report (SRFSR) and the personnel records, the facility failed to obtain and document the completion of 25 clock hours of annual training required for counselors in one of fourteen personnel records reviewed.

The findings include:

The SRFSR was reviewed on February 2, 2015 and re-reviewed on March 3, 2015. Fourteen personnel records were reviewed on March 3, 2015, but only five personnel records pertained to counselors. However, only two personnel records were required to have the regulated training hours based on their hire dates. The facility failed to ensure that the counselors obtained and documented at least 25 clock hours of annual training in employee record #13.

Employee #13 was hired into the project on December 30, 2007 and promoted to counselor status on September 20, 2009. The facility's training year was from January 1, 2014 through December 31, 2014. The facility only had 15.5 clock hours documented for the 2014 training year.

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

Plan of Correction

Clinical supervisors will be responsible for assuring that counselors complete a minimum of 25 clock hours of training annually. Clinical supervisors will be re-educated on this requirement by QM. The QM department at Allenwood will send out a quarterly report that lists staff and the trainings they have taken. Clinical supervisors will be responsible for assuring that staff have the appropriate number of training hours. The training hour report will be reviewed with counselors in supervision sessions.

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.

WHITE DEER RUN, INC.

BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/08/2015

INITIAL COMMENTS

This report is a result of an on-site Unusual Incident Investigation conducted on April 8, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the on-site investigation, White Deer Run, Inc. was found to be in compliance with applicable Chapters of 28 PA Code which pertain to the facility. Therefore no deficiencies were identified during this inspection and 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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 08/03/2015

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on August 3, 2015, by staff from the Division of Drug and Alcohol Licensure. Based on the findings related specifically to the complaint investigation, the allegations made against White Deer Run at Blue Mountain were unable to be substantiated. However, based on other findings during this investigation, the facility was found out of 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

705.6 (7) LICENSURE Bathrooms.
705.6. Bathrooms. The residential facility shall: (7) Maintain each bathroom in a functional, clean and sanitary manner at all times.

Observations
Based on a physical plant inspection, the facility failed to maintain each bathroom in a functional, clean, and sanitary manner at all times.

The findings include:

A physical plant inspection was conducted on August 3, 2015. The facility failed to maintain each bathroom in a functional, clean and sanitary manner at all times.

The bathroom in Room #103 had a light fixture that was inoperable. In addition, the wall above the shower had paint peeling from it.

The bathroom in Room #113 had paint peeling from the the wall above the shower.

These findings were reviewed with facility staff during the complaint investigation.

Plan of Correction
In Room #103, Light fixture was replaced and bathroom was repainted

In Room #113 bathroom will be repainted

Staff will monitor daily and report to maintenance any maintenance concerns within and outside of building so that buildings are kept in a functional, clean, sanitary manner at all times.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 09/15/2015

INITIAL COMMENTS

This report is a result of an Unusual Incident follow-up investigation conducted on September 15, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, White Deer Run, Inc. - Allenwood 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

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/24/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone/buprenorphine monitoring inspection conducted on March 23-24, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run 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

705.2 (1) LICENSURE Building exterior and grounds.

705.2. Building exterior and grounds. The residential 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 an observation during the physical plant inspection, it was determined that the project failed to maintain all structures on the grounds of the facility so as to be free from any danger to health or safety or in good repair at all times for the safety and well being of residents, employees, and visitors.

The findings include:

An inspection of the residential portion of the facility was conducted on March 23, 2016 at approximately 10:00 am to 1:00 pm.

Building #3, the Annex - There have been multiple incidents of damage to the outdoor siding on all sides of the building. The siding had tears with sharp edges that posed a safety risk to residents, employees, and visitors.

Building #1 - In the transportation office on the first floor, there was one electrical outlet without an electrical outlet face plate, posing a safety risk.

Building #13 - The building where the laundry is done did not appear to be maintained as evidenced by numerous

Plan of Correction

Maintenance department will purchase new siding and repair damaged areas.

Maintenance staff replaced the electrical outlet cover on 3/23/16.

Maintenance staff removed washing machine that was leaking and replaced it with new washing machine on 3/23/16.

Building #13 interior is scheduled to be repainted by maintenance staff

Physical plant will be monitored through leadership rounds conducted weekly by management team and monthly walk through conducted by the maintenance department staff. Facility Director will assure compliance.

amount of paint peeling off of the structure. Additionally, upon entering the building, there was water all over the walk area of the floor that could not be explained.

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

705.6 (7) LICENSURE Bathrooms.

705.6. Bathrooms. The residential facility shall: (7) Maintain each bathroom in a functional, clean and sanitary manner at all times.

Observations	Plan of Correction
Based on an observation during the physical plant inspection, it was determined that the project failed to maintain each bathroom in a functional, clean and sanitary manner at all times.	Building #1 upstairs, all shower areas will be re-caulked, repaired, replaced and remodeled as needed by maintenance staff.
The findings include:	Maintenance staff repaired the wall and fixed the hinges on the stall in building #11 on 3/23/16.
An inspection of the residential portion of the facility was conducted on March 23, 2016 at approximately 10:00 am to 1:00 pm.	Maintenance staff replaced the broke tile in Building #24 bathrooms as well as the rusted floor vent on 3/29/16.
Building # 1 - 2nd floor	Building #25, all shower areas will be re-caulked, repaired, replaced and remodeled as needed by maintenance staff. Additionally, any holes in walls will be patched and painted by maintenance staff.
Bathrooms in room 208 and 206 had molding and caulking that was peeling away from the showers. Bathroom in room 202 had a sink that was coming away from the wall. Bathroom in room 201 had a vent located on the ceiling that had a working light but the vent was missing the cover to the light. Room 209 had a broken light fixture above a bed. The shade of the florescent light was cracked and hanging off the fixture.	Physical plant will be monitored through leadership rounds conducted weekly by management team and monthly walk through conducted by the maintenance department staff. Facility Director will assure compliance.
Building #11	
First stall door on the left, located in the bathroom next to room 3, was hanging by the hinge with drywall breaking away from the wall.	

Building #24

Bathrooms in room 1 and 2 had broken tile with pieces missing in their bathrooms.

Bathroom in room 6 had a radiator in the bathroom that was covered in rust.

Building #25

Bathroom in room 25-4, had black mold in the cracks of the shower.

Bathroom in room 25-6, there was missing trim molding outside of the shower.

Bathroom in room 25-9, bathroom had tile coming up off the floor under the sink.

Bathroom in room 25-10, had a small hole to the lower right of the shower in the wood work with black mold.

Bathroom in room 25-11, had a big hole in the wall exposing wood behind it above the bed of a resident. In the bathroom, trim molding was pulled away from the wall.

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

709.28(c) LICENSURE Confidentiality

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

Observations

Based on a review of the project's consent to release, the facility failed to inform clients of their right to verbally revoke a consent to release of information in six of fourteen client records.

The findings include:

Fourteen client records were reviewed on March 23-24, 2016. The "Authorization for Release of Information" form

Plan of Correction

QI Coordinator facilitated a training directing staff to write "may verbally revoke" on each patients consent

All patient records to date have the correction made to them.

Medical Records will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct.

did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

IT department will correct the EMR consents by adding the "verbal revocation" to the consent, removing the HIV related information and removing the section identifying whether D&A, MH, HIV records may be released.

Client #5 was admitted on March 5, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #6 was admitted on March 2, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #7 was admitted on February 25, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #8 was admitted on March 15, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #12 was admitted on February 23, 2016 and discharged on March 9, 2016. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

Client #13 was admitted on March 11, 2016 and discharged on March 21, 2016. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent form in writing.

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

709.33(a) LICENSURE Notification of Termination

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

Observations

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

Plan of Correction

QI will send termination of treatment form and appeal form to all staff.

Clinical director will train clinical staff on the documentation and use of termination of treatment form.

The findings include:

Two client records requiring written notification to the client of facility's decision to involuntarily terminate the client's treatment were reviewed on March 23, 2016 and March 24, 2016. The facility failed to notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the facility in client record #11.

Client # 11 was admitted into treatment on September 23, 2015 and was involuntarily terminated from the facility on October 13, 2015. There was no documentation of written notification of the facility's decision to involuntarily terminate the client's treatment as of the date of the on-site inspection.

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

Clinical supervisor will audit AD charts to ensure compliance of termination of treatment form.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 08/15/2016

INITIAL COMMENTS

This report is a result of an onsite complaint investigation conducted on August 15, 2016, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the investigation, White Deer Run, Inc (Allenwood) 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

705.2 (2) LICENSURE Building exterior and grounds.

705.2. Building exterior and grounds. The residential facility shall: (2) Keep the grounds of the facility clean, safe, sanitary and in good repair at all times for the safety and well-being of residents, employees and visitors. The exterior of the building and the building grounds or yard shall be free of hazards.

Observations

A physical plant inspection was conducted on August 15, 2016. Based on this inspection, the facility failed to keep the facility clean, safe, sanitary and in good repair at all times as the following items were noted:

oUnit 2 ~ Room 2303 - had a light bulb that needed to be replaced

oUnit 2 ~ Room 2301 - the light fixture had a burnt stain on the plastic globe

oUnit 2 ~ Room 2313 - had a piece of wood broken off the window pain

oUnit 2 ~ Room 2310 - had a screw coming out of the window

oUnit 2 ~ A/C Unit needed cleaned

oBuilding 17 ~ bathroom floor was spongy and moved under foot

Plan of Correction

On 8/15/16 the following items were completed: Unit 2 room 2303, maintenance replaced the light bulb that needed replaced

Unit 2 room 2301 maintenance replaced the burnt light fixture with a new one.

Unit 2 room 2313 maintenance removed the broken piece of wood and replaced that section of the window pain

Unit 2 room 2310 maintenance screwed the screw that was coming out of the window back in.

On 9/5/16, Unit 2 AC unit had its filter changed, and is schedule to be maintained (filter replacement every 2 weeks). Additionally on 9/16/16 the facility has schedule bi-annual HVAC unit cleaning with an outside company, this is schedule for April/May 2017. Building # 17, Maintenance has replaced the sub-floor and installed new linoleum in the bathroom.

Continued monitoring of the physical plant will be conducted by maintenance on a monthly basis and by leadership team on during weekly walk throughs of the buildings/facility grounds.

These findings were reviewed with facility staff during the complaint investigation.

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.

WHITE DEER RUN, INC.

BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/20/2016

INITIAL COMMENTS

This report is a result of incident follow-up investigation conducted on October 20, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the investigation, White Deer Run-Allenwood handled the incident appropriately. Therefore, the facility was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/04/2016

INITIAL COMMENTS

This report is a result of an incident follow-up investigation conducted on October 20, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the investigation, White Deer Run (Allenwood) handled the incident appropriately, however a deficiently was identified.

Therefore, the facility was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiency was identified during this investigation and a plan of correction is required.

Plan of Correction

709.28(a)(1) LICENSURE Confidentiality

709.28. Confidentiality. (a) A written procedure shall be developed by the project director which shall comply with 4 Pa. Code 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure shall include, but not be limited to: (1) Confidentiality of client identity and records.

Observations

Based on a review of the incident report, witness statement and telephone interviews with facility staff, it was verified that a member of the facility's clinical staff took a video image of a group of clients.

The findings include:

A telephone interview with facility staff occurred on 10/20/2016. Additionally, an incident report dated 08/30/2016, a witness statement dated 08/19/2016 and an email dated 11/07/2016 were reviewed. It was determined that the facility failed to maintain the confidentiality of the client's identity.

Plan of Correction

1. Clinical director, director of safety/risk interviewed staff regarding the incident reported.

2. Clinical director, director of safety/risk, QI reviewed the security cameras to confirm concern re: confidentiality violation.

3. Clinical director gave employee improvement plan to staff who were aware of the incident.

4. Staff whom violated confidentiality via video image of patients was terminated.

5. Added refresher to annual mandatory staff training re: importance of patient confidentiality and electronic devices (scheduled 12/14/16 and 12/15/16).

6. HR facilitated a social media training, highlighting the use of electronic devices, what is/is not appropriate and all staff in attendance signed acknowledgement form (10/2016).

7. HR added social media training section to new hire orientation to improve training new staff on confidentiality (10/24/16).

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.

WHITE DEER RUN, INC.

BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/27/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on March 27, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, White Deer Run, 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

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/25/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on April 24-25, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, White Deer Run, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

705.6 (1) LICENSURE Bathrooms.
705.6. Bathrooms. The residential facility shall: (1) Provide bathrooms to accommodate staff, residents and other users of the facility.

Observations
The facility failed to ventilate toilets and wash rooms with an operable fan or window.

The physical plant inspection was conducted on April 25, 2017 at approximately 1:00 PM. Seven exhaust fans located in various buildings on the facility property were found to be inoperable at the time of the inspection.

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

Plan of Correction
Maintenance staff ordered parts to fix the defective fans in building # 25, additionally a new ceiling exhaust unit was installed in the public bathrooms in building # 25.

Maintenance staff ordered and installed new fans in the bathrooms of building #5.

All bathroom fans identified during the walk through have been fixed or replaced.

The facility will ensure that the fans are working on a weekly basis through the use of leadership rounds (internal building inspection) conducted by the facility management team as well was monthly maintenance walk through (internal physical plant/facility inspection).

709.53(a) LICENSURE Complete Client Record
709.53. 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
The facility failed to document a complete client record including discharge summaries in three of three inpatient client records.

Three discharged inpatient client records were reviewed on April 24-25, 2017. All three client records were required to include documentation of a discharge summary. Client

Plan of Correction
The Clinical Supervisors will re-educate the counselors during clinical supervision on regulatory standards/timeframes, time management and therapeutic boundaries, this will be completed in writing and verbally by 6/23/17.

Clinical supervisors will develop a schedule for clinical staff to have an hour weekly to work on their required paperwork.

records #6, 7 and 8 did not have documentation of a discharge summary.

Client #6 was admitted on 9/25/16 and discharged on 10/20/16. There was no discharge summary documented in client record #6.

Client #7 was admitted on 11/28/16 and discharged on 12/24/16. There was no discharge summary documented in client record #7.

Client #8 was admitted on 11/28/16 and discharged on 12/13/16. There was no discharge summary documented in client record #8.

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

This schedule will be developed and implemented by 6/23/17

Medical Records staff will conduct ongoing monitoring of discharge summaries and report to the clinical director/supervisors when counselors are not completing them in in a timely manner.

Ast. Clinical Director will audit 12 charts weekly for 3 months, with a focus on discharge summaries to ensure that discharge summaries are being completed within regulatory guidelines. Findings from the medical records and Ast. Clinical Directors audits will be reviewed during weekly supervisors meetings.

Counselor Ast and Counselors will have their Clinical supervisors review and co-sign their completed discharge summaries.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 02/09/2018

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on February 9, 2018 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, White Deer Run, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

705.7 (b) (2) LICENSURE Food service.

705.7. Food service. (b) A residential facility may operate a central food preparation area to provide food services to multiple facilities or locations. A residential facility that operates an onsite food preparation area or a central food preparation area shall: (2) Clean and disinfect food preparation areas and appliances following each prepared meal.

Observations

A physical plant inspection was conducted on February 9, 2018. Based on this review the facility failed to clean and disinfect food preparation appliances.During the physical plant inspection of the Detox the juice and hot chocolate machines were observed to be dirty. These appliances appeared to have not been cleaned for some time.

Plan of Correction

An approved Plan of Correction is not on file.

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.

WHITE DEER RUN, INC.
BOX 97, 360 WHITE DEER RUN ROAD
ALLENWOOD, PA 17810

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 05/08/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on May 7-8, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run, 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 facility records conducted during the on-site inspection, and based on staff interviews conducted during the on-site inspection, the facility failed to ensure that all of its staff had the required training in communicable diseases.

Staff Person #23 was hired a support staff person on 10/29/2015, and was due to have 6 hours of HIV/AIDS training, and 4 hours of TB/STD training by 10/29/2017, but the staff person had not documented training in HIV/AIDS or TB/STD training at the time of the on-site inspection.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Staff person #23 will attend HIV/AIDS training on 6/21/18 and TB/STD training on 6/5/18. Staff person #23 will submit training certificate and evaluation to clinical supervisor and QI department.

QI will send out bi-weekly tracking of staff training, including required trainings. Clinical supervisor will monitor tracking list to ensure staff compliance with state required trainings within regulatory timeframes.

705.4 (3) LICENSURE Counseling areas.

705.4. Counseling areas. The residential facility shall: (3) Ensure privacy so that counseling sessions cannot be seen or heard outside the counseling room. Counseling room walls shall extend from the floor to the ceiling.

Observations

Based on the physical plant inspection conducted on 05/08/2018, the facility failed to ensure privacy during counseling sessions.

During the physical plant inspection there was an individual

Plan of Correction

Clinical Director reviewed regulation 705.4 with all clinical staff during shift report meeting on 5/9/18.

Clinical Director/Ast Clinical Director will review/train new staff during monthly new hire orientation on regulation

counseling session being conducted in room 8-7. The door of room 8-7 was open, and the counseling session could be heard from outside of the room.	705.4.
These findings were reviewed with facility staff as part of the inspection process.	Clinical supervisors will conduct bi-weekly spot checks to ensure clinical staff are complying with regulatory standard of 705.4 for 6 months. Noncompliance will be addressed during staff supervision/competencies.

705.7 (b) (6) LICENSURE Food service.

705.7. Food service. (b) A residential facility may operate a central food preparation area to provide food services to multiple facilities or locations. A residential facility that operates an onsite food preparation area or a central food preparation area shall: (6) Store all food items off the floor.

Observations	Plan of Correction
Based on the physical plant inspection conducted on 05/08/2018, the facility failed to ensure that it did not store food on the floor.	Upon delivery food will be stacked on shelving per regulation 705.7.
There were 4 cases of milk stacked 2 by 2 stored on the floor of the walk in refrigerator located in the dry storage area.	Dietary staff will be educated on regulation 705.7 and the importance of proper food storage.
These findings were reviewed with facility staff as part of the inspection process.	Dietary manager will conduct random checks for compliance within all of the food storage areas.

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.

WHITE DEER RUN OF ALLENTOWN
1259 SOUTH CEDAR CREST BOULEVARD, SUITE 308
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/10/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 10, 2015 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, White Deer Run of Allentown 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

Plan of Correction
The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

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

Plan of Correction
Clinical Director completed an in-service with clinical staff on

document a complete client record on an individual, which includes documentation of progress notes, case consultation notes, discharge summaries, and follow-up information in nine of eleven client records reviewed.

The findings include:

Eleven client records requiring a complete client record on an individual were reviewed on March 10, 2015. The facility did not provide a complete client record for client #s 1, 2, 3, 4, 5, 6, 8, 9, and 10.

Client #1 was admitted to treatment on November 14, 2014 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/8/14, 12/15/14, 12/22/14, 01/27/15, and 02/03/15 were missing from the client record. Additionally, the facility failed to include documentation of a quarterly case consultation in the client's record.

Client #2 was admitted to treatment on December 16, 2014 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/16/14 and 01/13/15 were missing from the client record.

Client #3 was admitted to treatment on November 20, 2014 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of quarterly case consultations in the client's record.

Client #4 was admitted to treatment on December 12, 2014 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/12/14, 12/22/14, 12/30/14, 01/06/15, 01/27/15, 02/03/15, and 02/17/15 were missing from the client record.

Client #5 was admitted to treatment on November 21, 2014 and was still an active client at the time of the on-site inspection. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/03/14, 12/08/14, 12/15/14, 12/17/14, 12/19/14, and 12/22/14 were missing from the client record.

Client #6 was admitted to treatment on December 02, 2014 and was discharged on July 03, 2014. The facility failed to

3/13/2015 to assure understanding of this standard. Clinical Director will conduct monthly chart audits as well as monthly and/or quarterly supervision of clinical staff to assure ongoing compliance of this standard. Clinical Supervisor will address during monthly individual supervisions with each counselor any deficiencies in this area and develop an individual development plan identifying areas to be improved upon in regard to documentation for client records. Clinical Supervisor will be responsible for assuring all documentation is completed and filed in client's records.

Clinical Supervisor and responsible clinician will review charts of current clients in treatment and submit all missing documentation where applicable or possible and if documentation cannot be created an administrative letter will be filed in that chart with an explanation as to what is missing and why it cannot be created. This will be completed by April 24th.

include documentation of progress notes that were recorded on the client's record of service. Progress notes for 12/12/13, 05/23/14, 05/30/14, 06/06/14, and 07/03/14 were missing from the client record. In addition, the facility failed to include documentation of quarterly case consultations in the client's record. Additionally, there was no follow up information documented as of the date of the on-site inspection.

Client #8 was admitted to treatment on June 10, 2014 and was discharged on October 22, 2014. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 07/08/14, 07/15/14, and 09/23/14 were missing from the client record.

Client #9 was admitted to treatment on August 26, 2014 and was discharged on December 26, 2014. The facility failed to include documentation of follow-up information as of the date of the on-site inspection.

Client #10 was admitted to treatment on August 29, 2014 and was discharged on October 09, 2014. The facility failed to include documentation of progress notes that were recorded on the client's record of service. Progress notes for 09/10/14, 09/17/14, 09/24/14, and 10/08/14 were missing from the client record. Additionally, the facility failed to include documentation of a discharge summary in the client's record as of the date of the on-site inspection.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN OF ALLENTOWN
1259 SOUTH CEDAR CREST BOULEVARD, SUITE 308
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/16/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 16, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Allentown 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

705.23 (3) LICENSURE Counseling or activity areas and office space
705.23. Counseling or activity areas and office space. The nonresidential facility shall: (3) Ensure privacy so that counseling sessions cannot be seen or heard outside the counseling room. Counseling room walls shall extend from the floor to the ceiling.

Observations
Based on observation and an overheard counseling session during the on-site licensure inspection, the facility failed to ensure privacy so that counseling sessions could not be seen or heard outside the counseling room.

The findings include:

On March 16, 2016, a counseling session between a counselor and patient was overheard by the licensing specialist. The licensing specialist was located in a group counseling room directly next to another group counseling room where the counseling session was taking place. The counseling session was overheard from the licensing specialists group counseling room during the licensing visit. This was also verified by the facility director when the licensing specialist asked the facility director to come into where the licensing specialist was.

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

Plan of Correction
Clinical Supervisor reviewed with staff that sound machines are to be turned on whenever a counselor is having an individual or group session with clients to ensure privacy at the March 22, 2016 staff meeting. Additional sound machines were purchased and put into place at all counselor's offices and group rooms on March 30, 2016. Weekly site inspections by the office manager and/or Clinical Director will be completed to ensure adherence to the policy.

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

Observations

Plan of Correction

Based on a review of client records, the facility failed to obtain an informed and voluntary consent to release in four of ten client records.

The findings include:

Based on a review of these records, the facility's consent to release client information was observed to be out of compliance with 42 CFR and State Law 4 Pa Code 255.5(b).

The "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing.

Ten client records were reviewed on March 16, 2016 for informed and voluntary consent to release client information forms. The facility failed to obtain or document an informed and voluntary consent to release client identifying information in client records # 1, 2, 3, and 9.

Client #1 was admitted on July 22, 2015 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

Client #2 was admitted on January 4, 2016 and was still an active client at the time of inspection. On a consent form dated 1/04/16, the facility allowed for the release of the client's alcohol, drug, or substance abuse records to probation thus exceeded the limitations imposed at 4 Pa code 255.5(b). In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Client #3 was admitted on December 18, 2015 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent required the client to revoke the consent in writing.

Client #9 was admitted on January 21, 2016 and discharged on March 1, 2016. On a consent to release form signed by the client on January 21, 2016 the facility failed to check off the information to be released. In addition, the facility failed to comply with 42 CFR as the consent required the client to revoke their consent in writing.

Clinical Director provided a training on 4/19/16 on the proper documentation for the Release of Information on the consents. A line will be added to the consent release of information form to allow for verbal revocation. Current and future clients will sign consents to release information that is compliant with 42 CFR. Clinical Director will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct. All training of staff will be complete and charts will be compliant by May 20, 2016. Quality Director and Regional VP are currently working with corporate to develop a new consent to release information form that will be compliant with State and Federal regulations.

These findings were reviewed with facility staff during the licensing 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.

WHITE DEER RUN OF ALLENTOWN
1259 SOUTH CEDAR CREST BOULEVARD, SUITE 308
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/12/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 11-12, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Allentown 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 facility records conducted as part of the presubmission process and interviews conducted during the onsite inspection, the facility failed to ensure that all of its staff had the required training in communicable diseases. Staff Person #7 was hired as an office manager on 03/02/2015 and was required to have 6 hours of HIV/AIDS and 4 hour of TB/STD training by 03/02/2017. At the time of the onsite inspection, it was not documented that the staff person had received any of these trainings. These findings were reviewed with the facility staff as part of the inspection process.

Plan of Correction

Clinical Director will review and assure mandatory communicable diseases for all staff are completed in a timely manner.

Clinical staff within 1 year of hire

Administrative staff within 2 years of hire.

Clinical Director will review HR files on a quarterly basis to ensure completion.

Current staff Person # 7 has completed 4 hours TB/STD training as of April 25th. She will complete HIV training by July 30, 2017

709.28 (c) (3) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (3) Purpose of disclosure.

Observations

The client records reviewed during the onsite inspection for

Plan of Correction

Clinical Director will schedule a training of all staff at all

clients #2 and #7 had informed and voluntary consent to release information forms that did not list the purpose of the release of information.Client #2's informed consent to release information form for Medicaid funding signed by the client on 11/28/2016 did not list the purpose of the release.Client #2's informed consent to release information form for county funding signed by the client on 01/05/2017 did not list the purpose of the release.Client #6's informed consent to release information form for a health care provider signed by the client on 02/23/2017 did not list the purpose of the release. These findings were reviewed with facility staff as part of the inspection process.	facilities to ensure proper completion of consents and release of information. Staff training will be conducted on May 23, 2017. Monthly chart reviews by the Clinical Director and staff will ensure that all consent and release of information documentation will be completed correctly.

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.

WHITE DEER RUN OF ALLENTOWN
1259 SOUTH CEDAR CREST BOULEVARD, SUITE 308
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/09/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 9, 2018, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, White Deer Run of Allentown 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

709.28 (c) (1) LICENSURE Confidentiality
§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations
Based on a review of facility records conducted during the on-site inspection, the facility failed to ensure that it included all of the required documentation on its consent to release information forms.

Plan of Correction
All staff have been trained to complete the release in its entirety before releasing any information. Training occurred during staff meeting on April 10th, 2018. Clinical Supervisor will monitor through monthly review charts.

Client # 9 came to the facility on 1/19/2018, to have an intake, evaluation and referral activity performed. The signed consent to release information for the client's healthcare provider, dated 1/19/2018, did not include the purpose of the release.

These findings were reviewed with facility staff as part of the inspection process.

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 facility records conducted during the on-site inspection, and based on staff interviews conducted during the on-site inspection, the facility failed to ensure that it documented fire extinguisher training for its staff upon their hire.

Plan of Correction
Clinical director will document training of fire extinguishers within the first week of employment with all new hired staff. Fire safety is reviewed with all staff on an annual basis.

Staff Person # 2 was hired on 9/12/2017, but the first

documented fire extinguisher training for the staff person is 11/14/2017.

These findings were reviewed with facility staff as part of the inspection process.

709.93(a)(9) 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: (9) Aftercare plan, if applicable.

Observations

Based on a review of facility records conducted during the on-site inspection, the facility failed to ensure that it documented client aftercare plans in 1 of 2 applicable records reviewed.

Client # 5 was admitted for outpatient treatment on 8/30/2017, and successfully completed treatment on 10/27/2017, but there was no documented aftercare plan for the client.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Staff were trained during the staff meeting on April 10th that aftercare plans must be completed prior to discharge of clients and filed in the closed chart.

All closed charts will be reviewed by Clinical Director for compliance.

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

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

Observations

Based on a review of facility records conducted during the on-site inspection, and based on staff interviews conducted during the on-site inspection, the facility failed to ensure that all of its counselors received all of the required annual training in the 2017 training year.

Staff Person #3, a counselor, only received 18 hours of training in the year 2017.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Clinical Director will document and track all training of counselors to ensure that each counselor receives the correct amount of approved training annually. This has already begun for the 2018 year.

709.44(a)(3) LICENSURE Psychosocial evaluation

709.44. Client records. (a) The project shall maintain a client record on an individual which shall include, but not be limited to: (3) Psychosocial evaluation.

Observations

Based on a review of facility records conducted during the

Plan of Correction

Staff will complete an evaluative note after the assessment is

on-site inspection, the facility failed to document psychosocial evaluations in 6 of 6 intake, evaluation and referral activity records.

Client records #s 8, 9, 10, 11, 12 and 13 did not have documented psychosocial evaluations.

These findings were reviewed with facility staff as part of the inspection process.

completed and document in the chart.

Clinical supervisor will monitor by monthly chart audits.

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.

COVE FORGE RENEWAL CENTER
624 BROAD STREET
JOHNSTOWN, PA 15906

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/17/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 17, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Cove Forge Renewal Center was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection.

Plan of Correction

704.6(a) LICENSURE Clinical Supervisor Qualifications

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

Observations

Based on a review of the Staffing Requirements Facility Summary Report forms for all of the facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.The findings include:The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.The findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care.

Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis.

Completion date July 1, 2015.

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.

COVE FORGE RENEWAL CENTER

624 BROAD STREET
JOHNSTOWN, PA 15906

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/04/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 4, 2017 by staff from the Department of Drug and Alcohol Programs, Program Licensure Division. Based on the findings of the on-site inspection, Cove Forge Renewal Center was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

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.

NEW PERSPECTIVE AT WHITE DEER RUN

240 SOUTH 8TH STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/07/2015

INITIAL COMMENTS

This report is a result of an initial on-site licensing inspection conducted on April 7, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the initial inspection, White Deer Run Inc. New Perspective was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

Since this was the initial inspection conducted, not all regulations were reviewed. During future inspections, all regulations will be reviewed for compliance.

The following deficiencies were identified.

705.22 (2) LICENSURE Building exterior and grounds.

705.22. Building exterior and grounds. The nonresidential facility shall: (2) Keep the grounds of the facility clean, safe, sanitary and in good repair at all times for the safety and well being of clients, employees and visitors. The exterior of the building and the building grounds or yard shall be free of hazards.

Observations

Based on a physical plant inspection, the facility failed to ensure the exterior of the building grounds were free of hazards.

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

A physical plant inspection was conducted on April 7, 2015. There were two sets of steps leading to the porch at the rear of the building. The concrete steps on the side of the rear porch were broken and contained a significant gap between the second and third steps.

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

705.28 (a) (1) (iii) LICENSURE Fire safety.

705.28. Fire safety. (a) Exits. (1) The nonresidential facility shall: (iii) Maintain each ramp, interior stairway and outside

steps exceeding two steps with a well-secured handrail and maintain each porch that has over an 18 inch drop with a well-secured railing.

Observations
Based on a physical plant inspection, the facility failed to maintain each ramp, interior stairway, and outside steps exceeding two steps with a well secured handrail, and maintain each porch that has over an 18 inch drop with a well secured railing.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

A physical plant inspection was conducted on April 7, 2015. The porch located at the rear of the facility has two sets of steps with three steps on each set. There was not a secure handrail on either set of steps.

The findings were discussed with facility staff during the licensing 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.

NEW PERSPECTIVE AT WHITE DEER RUN

240 SOUTH 8TH STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/13/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on November 13, 2015, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Perspective at White Deer Run 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

705.10 (d) (1) LICENSURE Fire safety.

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

Observations
Based on a review of the fire drill logs, the facility failed to conduct unannounced fire drills at least once per month as required by regulation.

Plan of Correction
Staff was informed on October 1, 2015 that they are required to conduct monthly unannounced fire drills. Staff began conducting monthly unannounced fire drills alternating different shifts of the day on October 19, 2015. Clinical supervisor reviews documentation of monthly fire drills with Safety officer of facility each month.

The findings include:

The fire drill logs were reviewed during the renewal inspection on 11/13/15. There was no documentation of unannounced fire drills for the months of May 2015 - September 2015.

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

709.28(b) LICENSURE Confidentiality

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

Observations
Based on a physical plant inspection, the facility failed to ensure that hard copy client records were secured within locked storage containers.

Plan of Correction
On November 13, 2015, Clinical Director stated that as of that date the key to the file room is to be kept in a secure location (a drawer in the staff bathroom) and each staff person will be required to obtain the key and return it to its

	secure location after exiting the file room.
The findings include:	Clinical Supervisor has been conducting weekly inspection that the file room is kept secure at all times.
A physical plant inspection was conducted at approximately 1:45 pm, during the renewal inspection on 11/13/15. Hard copy client records were observed to be stored in filing cabinets, which were kept in a storage closet located in the 2nd floor hallway. It was observed that the key to the storage closet was left in door's keyhole. The facility confirmed that the key to this record storage closet is kept in the keyhole, as there is only one key available for staff to access this closet. The facility also confirmed that the filing cabinets also remain unlocked.	
The findings were reviewed with staff during the licensing inspection.	

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	**Plan of Correction**
Based on the review of client records, the facility failed to ensure that a complete record was documented in three of seven client records reviewed.	Copies of records of service will be kept with each client?s file to show documentation of client?s attendance. Record of service will document whether group or individual appointments as well as duration of appointment. This was conveyed to each staff member at the staff meeting on November 16th and via email to part-time staff who were not present.
The findings include:	
Seven client records were reviewed for documentation of a complete client record during the renewal inspection on 11/13/15. The facility failed to document a complete record in client records # 3, 5, and 6.	Clinical Supervisor reviewed with staff on November 16th to complete discharge summaries within 7 days of discharge and file accordingly in client's charts.
Client # 3 was admitted into treatment on 8/13/15 and was still active at the time of the inspection. Progress notes in the client's record indicated the client attended individual counseling sessions on the following dates: 9/1/15, 9/6/15, 9/22/15, 10/22/15, and 11/5/15. Additionally, progress notes in the client's record indicated the client attended group counseling sessions on the following dates: 8/19/15, 10/7/15, 10/14/15, 10/21/15, 10/28/15, 11/4/15, and 11/11/15. A complete record of service for these individual and group counseling sessions was not documented in the client's record.	Clinical Supervisor will perform monthly chart audits to ensure compliance of procedure.
Client # 5 was admitted into treatment on 7/31/15 and was discharged on 8/26/15. The client's record indicated the client attended an individual counseling session on 7/31/15. A complete record of service for this individual counseling session was not documented in the client's record.	
Client # 6 was admitted into treatment on 6/25/15 and was discharged on 10/1/15. A discharge summary was not documented in the client's record.	
These findings were reviewed with facility staff during the licensing 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.

NEW PERSPECTIVE AT WHITE DEER RUN
240 SOUTH 8TH STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/09/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 9, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Perspective at White Deer Run 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

709.28 (c) (1) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record in four of eight client records.

The findings include:

Eight client records were reviewed on March 9, 2016. The facility failed to obtain or document an informed and voluntary consent to release information in client records # 1, 2, 3, and 8.

Client #1 was admitted on February 1, 2016 and was still an active client at the time of inspection. A consent form dated 2/17/16 allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to probation. The facility failed to check off the purpose of the disclosure. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Plan of Correction

Clinical Director provided a training 4/18/16 on the proper documentation for the Release of Information on the consentsClinical director will provide training to staff that is compliant with 42 CFR. A line will be added to the consent release of information form to allow for verbal revocation. Current and future clients will sign consents to release information that is compliant with 42 CFR. Clinical Director will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct. All training of staff will be complete and charts will be compliant by May 20, 2016. Quality Director and Regional VP are currently working with corporate to develop a new consent to release information form that will be compliant with State and Federal regulations

Client #2 was admitted on February 1, 2016 and was still an active client at the time of inspection. The facility failed to comply with 42 CFR as the consent only allowed the client to revoke the consent form in writing.

Client #3 was admitted on February 3, 2016 and was still an active client at the time of inspection. A consent form dated 2/03/16 allowed for the release of the client's alcohol, drug, or substance abuse records and mental health records to probation. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #8 was admitted on January 7, 2016 and discharged on March 7, 2016. A consent form signed by the client on January 7, 2016 did not have the purpose of the disclosure and the information to be released checked. In addition, the facility failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

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

709.92(b) LICENSURE Treatment and rehabilitation services

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

Observations

Based on a review of client records, the facility failed to document treatment and rehabilitation plan reviews and updates within sixty days, in two of four client records.

The findings include:

Four client records requiring treatment plan reviews and updates were reviewed on March 9, 2016. The facility failed to document treatment plan reviews and updates within sixty days, in client records #5 and #6.

Client #5 was admitted on October 9, 2015 and discharged on March 2, 2016. The comprehensive treatment plan was completed on 10/13/15. A treatment plan update was due by 12/13/2015. The facility failed to document the completion of a treatment plan update.

Client #6 was admitted on October 5, 2015 and discharged on March 1, 2016. The comprehensive treatment plan was completed on 11/13/15. A treatment plan update was due by 2/9/2015. The facility failed to document the completion of a treatment plan update.

Plan of Correction

A former staff was responsible for the missed documentation in regard to the treatment plan updates on the two client records noted in the deficiency. Clinical supervisor reviewed with current staff the policy regarding treatment updates needing to be completed every 60 days at the staff meeting on March 16, 2016. Clinical Supervisor will monitor adherence to this policy through monthly chart reviews and supervision with staff.

These findings were reviewed with facility staff during the licensing 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.

NEW PERSPECTIVE AT WHITE DEER RUN
240 SOUTH 8TH STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/29/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 29, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Perspective at White Deer Run 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

704.7(b) LICENSURE Counselor Qualifications

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

Observations

Based on a review of facility records conducted as part of the presubmission process and during the onsite inspection, and staff interviews conducted during the onsite inspection, the facility failed to ensure that all of their counselors had the required experience qualifications.Staff person #5 was hired as a Bachelor's degree level counselor on 08/08/2016, but the staff person only had 4 months of clinical experience at the time the staff person was made a counselor.These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

All candidates for consideration will be reviewed by Quality Management and HR prior to an offer being extended. Counselor will be reclassified as a Counselor Assistant and will receive weekly supervision for 8 months to meet the qualifications for Counselor.

Staff will be reclassified as of 4/17/17 and complete his 8 month classification as of 12/17/17.

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 facility records conducted as part of the presubmission process and during the onsite inspection, the facility failed to ensure that all of the staff of the facility had received the mandatory 6 hours of HIV/AIDS training and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training within the required timeframes. Staff person #6 was hired hired as an office manager on 11/24/2014, and was required to have all of the required training in communicable diseases by 11/24/2016, but the staff person did not receive the 6 hours of HIV/AIDS training until 02/27/2017, and the 4 hours of TB/STD training until 02/28/2017.These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Clinical Director will review and assure mandatory communicable diseases for all staff are completed in a timely manner.

Clinical staff within 1 year of hire

Administrative staff within 2 years of hire.

Clinical Director will review HR files on a quarterly basis to ensure completion.

709.28 (c) (3) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (3) Purpose of disclosure.

Observations

Based on a review of facility records conducted during the onsite inspection, the facility failed to ensure that the correct purpose was included on informed consent to release information forms in 1 of 7 records reviewed.The informed consent to release information to the funding source for client #3's treatment, a Single County Authority, signed by the client on 09/27/2017, lists legal court system as the purpose of the consent.These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Clinical Director will schedule a training of all staff at all facilities to ensure proper completion of consents and release of information. Staff training will be conducted on May 8, 2017.

Monthly chart reviews will ensure that all consent and release of information documentation will be completed correctly.

709.28 (c) (6) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (6) Date, event or condition upon which the consent will expire.

Observations

Based on a review of facility records conducted during the onsite inspection, the facility records for clients #2 and #7 had signed informed consent to release information forms that were dated to expire prior to the signature date of the client.The informed consent to release information to the criminal justice system for client #2 was signed by the client on 12/20/2016, but was dated to expire 05/20/2016.The informed consent to release information to the criminal justice system for client #7 was signed by the client on 09/13/2016, but was dated to expire 02/13/2016.The informed consent to release information to the funding source for client #7's treatment was signed by the client on 09/13/2016, but was dated to expire 02/13/2016. These findings were discussed with facility staff as part of th inspection process.

Plan of Correction

Clinical Director will schedule a training of all staff at all facilities to ensure proper completion of consents and release of information. Monthly chart reviews will ensure that all consent and release of information documentation will be completed correctly.

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.

NEW PERSPECTIVES AT WHITE DEER RUN
3030 CHESTNUT STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/25/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and inspection conducted for the approval to use a narcotic agent, specifically buprenorphine, in the treatment of narcotic addiction. This inspection was conducted on March 24, 2015 through March 25, 2015, by staff from the Department of Drug and Alcohol Programs, Division of Program Licensure. Based on the findings of the on-site inspection, New Perspectives At White Deer Run was found not to be in compliance with the applicable chapters of 4 PA Code and 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 Staffing Requirements Facility Summary Report forms for all facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.

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

705.7 (b) (5) LICENSURE Food service.
705.7. Food service. (b) A residential facility may operate a central food preparation area to provide food services to

multiple facilities or locations. A residential facility that operates an onsite food preparation area or a central food preparation area shall: (5) Keep cold food at or below 40F, hot food at or above 140F, and frozen food at or below 0F.

Observations
Based on the physical plant inspection, the facility failed to keep frozen food at or below 0 degrees Fahrenheit in two of two freezers.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

A physical plant inspection was conducted on March 24, 2015, at approximately 1:30 PM. During this time, it was reported that the kitchen staff read the temperature logs one time a day at the beginning of the day and prior to the start of breakfast preparations.

Freezer #1 is located in the kitchen, where only kitchen staff have access. The freezer temperature read 6 F at the time of inspection. After a review of the freezer temperature log for freezer #1, it was discovered that the freezer measured above 0 F in 14 out of 30 days in June 2014; 17 out of 31 days in July 2014; 22 out of 31 days in August 2014; 20 out of 30 days in September 2014; 21 out of 31 days in October 2014; 11 out of 30 days in November 2014; 18 out of 31 days in December 2014; 16 out of 31 days in January 2015; 9 out of 28 days in February 2015; and 16 out of 24 days (including the day of the inspection) in March 2015.

Freezer #2 is located in the dining area and is directly accessible by the clients. The freezer temperature read 1 F at the time of inspection. After a review of the freezer temperature log for freezer #2, it was discovered that the freezer measured above 0 F in 14 out of 31 days in July 2014; 19 out of 31 days in August 2014; 15 out of 30 days in September 2014; 22 out of 31 days in October 2014; 16 out of 30 days in November 2014; 15 out of 31 days in December 2014; 18 out of 31 days in January 2015; 15 out of 28 days in February 2015; and 11 out of 24 days (including the day of the inspection) in March 2015.

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

709.63(a) LICENSURE Client record

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

Observations
Based on a review of client records, the facility failed to document a complete client record on an individual, which includes follow-up information and discharge summary in two of six client records reviewed.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Twenty-one client records were reviewed on March 24, 2015 through March 25, 2015. Six client records pertaining to inpatient short-term detoxification required a complete client record on an individual. The facility did not provide a complete client record for client records ,#1 and 6.

Client #1 was admitted to treatment on February 2, 2015 and was discharged on February 7, 2015. The facility failed to include documentation of a discharge summary in the client record as of the date of the inspection. In addition, the facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #6 was admitted to treatment on February 17, 2015 and was discharged on February 23, 2015. The facility failed to include documentation of a discharge summary in the client record as of the date of the inspection. In addition, the facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

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

709.53(a) LICENSURE Complete Client Record

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

Observations

Based on a review of client records, the facility failed to document a complete client record on an individual, which is to include follow-up information in three of six client records reviewed.

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Twenty-one client records were reviewed on March 24, 2015 through March 25, 2015. Six client records pertaining to inpatient non-hospital residential required a complete client record on an individual. The facility did not provide a complete client record for client records, #2, 3, and 5.

Client #2 was admitted to treatment on January 27, 2015 and was discharged on February 24, 2015. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #3 was admitted to treatment on October 1, 2014 and

was discharged on November 1, 2014. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #5 was admitted to treatment on January 30, 2015 and was discharged on February 5, 2015. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

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

709.93(a) LICENSURE Client records

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

Observations

Based on a review of client records, the facility failed to document a complete client record on an individual, which includes follow-up information and an individualized treatment and rehabilitation plan in four of eleven client records reviewed.

The findings include:

Twenty-one client records were reviewed on March 24, 2015 through March 25, 2015. Eleven client records pertaining to outpatient required a complete client record on an individual. The facility did not provide a complete client record for client records, #16, 17, 18, and 19.

Client #16 was admitted to treatment on October 14, 2014 and was discharged on December 2, 2014. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #17 was admitted to treatment on October 21, 2014 and was discharged on December 10, 2014. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #18 was admitted to treatment on May 20, 2014 and was discharged on December 11, 2014. The facility failed to include documentation of any follow-up information in the client record as of the date of this inspection.

Client #19 was admitted to treatment on October 20, 2014 and was discharged on December 25, 2014. The facility failed to include documentation of a signed and dated

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

individualized treatment and rehabilitation plan in the client record.

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 client records, the facility failed to document a physician signature on the individual treatment plans for medical assistance clients in two of two client records.

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings included:

Twenty-one client records were reviewed on March 24, 2015 through March 25, 2015. Eleven of the client records were pertaining to the outpatient activity. Two of the eleven records reviewed were required to have a physician signature on the individual treatment plans. The individual treatment plans contained in client records, #11, and 19 did not contain a physician signature.

Client #11 was admitted to treatment on January 8, 2015 and was still an active client at the time of the inspection. The initial treatment and rehabilitation plan was developed and signed by the client on January 8, 2015 and a treatment plan update was signed/dated on January 16, 2015. Both the initial treatment plan and the treatment plan update did not include the physician's signature.

Client #19 was admitted to treatment on October 20, 2014 and was discharged on December 25, 2014. An initial treatment and rehabilitation plan was developed and signed by the client on October 20, 2014 that did not include a physician signature. Additionally, a treatment plan update was due to be signed and dated by the physician no later than December 20, 2015. The physician failed to sign and date a treatment plan update for client #19.

These findings were reviewed with facility staff during the licensing 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.

NEW PERSPECTIVES AT WHITE DEER RUN
3030 CHESTNUT STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/09/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and an on-site inspection conducted for the approval to use a narcotic agent, specifically buprenorphine, in the treatment of narcotic addiction. This inspection was conducted on March 9, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Perspectives at White Deer Run, was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

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 personnel and training records, the facility failed to provide documentation of HIV/AIDS and TB/STD training in one of seven applicable records reviewed.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Seven personnel records which required documentation of mandatory communicable disease training were reviewed on March 9, 2016. The facility failed to provide documentation of HIV/AIDS and TB/STD training for employee #5.

Employee #5 was hired 3/3/2014 as a driver. This employee was required to obtain six hours of HIV/AIDS and 4 hours of TB/STD training by 3/3/2016. Employee #5 failed to obtain the training as of the date of the inspection.

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

705.7 (b) (5) LICENSURE Food service.

705.7. Food service. (b) A residential facility may operate a central food preparation area to provide food services to multiple facilities or locations. A residential facility that operates an onsite food preparation area or a central food preparation area shall: (5) Keep cold food at or below 40F, hot food at or above 140F, and frozen food at or below 0F.

Observations

Based on an observation during the physical plant inspection, the facility failed to keep frozen food at or below 0 degrees fahrenheit in one of two freezers.

The findings include:

A physical plant inspection was conducted on March 9, 2016 at approximately 10:30 am.

A freezer holding food that is located in the laundry room of Kitchen Hall, had a thermometer that read 2 degrees fahrenheit.

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

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

705.10 (c) (4) LICENSURE Fire safety.

705.10. Fire safety. (c) Fire extinguisher. The residential facility shall: (4) Instruct all staff in the use of the fire extinguishers 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 upon employment, in two of seven personnel records.

The findings include:

Seven personnel records were reviewed on March 9, 2016. The facility failed to document the completion of fire extinguisher training upon employment, in personnel records #4 and #7.

Employee # 4 was hired on May 18, 2015. There was no record that this training was complete by the date of the inspection.

Employee # 7 was hired on November 10, 2015. There was no record that this training was complete by the date of the inspection.

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

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

705.10 (d) (3) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential 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 document the instruction of staff to perform assigned tasks during emergencies in two of seven personnel records.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Seven personnel records were reviewed on March 9, 2016. The facility failed to document the completion of emergency training in personnel records, #4 and 7.

Employee # 4 was hired on May 18, 2015. There was no record that this training was complete by the date of the inspection.

Employee # 7 was hired on November 10, 2015. There was no record that this training was complete by the date of the inspection.

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

705.10 (d) (4) LICENSURE Fire safety.

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

Observations
Based on the review of the fire drill record, the facility failed to ensure that fire drills were accurately documented on the fire drill reports.

Plan of Correction
This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

The fire drill record was reviewed on March 9, 2016. Twelve months of fire drills were reviewed. The facility's hours of operation are from 24 hours a day, seven days a week.

Fire drills for 10/11/15, 9/30/15 and 8/3/2015 all state "Time of Activated Alarm" was 2:45 pm. Fire drills for 3/31/2015 and 4/29/15 do not state if the time was a.m. or p.m.

In addition, the fire drill for 11/10/15 did not indicate if this was an actual fire, a false alarm, or a fire drill; and the fire drill for 1/29/2016 did not indicate the exit route used.

These findings were reviewed with facility staff during the

licensing process.

709.28 (c) (1) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations

Based on a review of client records, the facility failed to obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record in eight of eight client records.

The findings include:

Eight client records were reviewed on March 9, 2016 for informed and voluntary consent to release client information forms. The facility failed to obtain an informed and voluntary consent to release information from the client in client records #1 through #8.

The facility's consent to release client information form is a standardized form. The consent form included the following statement: "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation."

42 CFR Part 2, Subpart C, subsection 2.31 (a) Required elements, specifies that the following information must be included on the written consent: "(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it." Therefore, as per 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) the consent to release client information form can be revoked by the client at any time and there is no restriction on the manner in which they may revoke it.

The facility failed to adhere to the requirements outlined in the federal confidentiality regulations by requiring the clients to revoke consent forms in writing.

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

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

709.62(c)(6) LICENSURE Psychosocial Eval

709.62. Intake and admission. (c) Intake procedures shall include documentation of the following: (6) Psychosocial evaluation.

Observations

Based on a review of patient records, the facility failed to document a psychosocial evaluation in two of four detox patient records.

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Four client records were reviewed on March 9, 2016. Four patient records required the documentation of a psychosocial evaluation. The facility failed to provide documentation of a psychosocial evaluation in patient records, # 1 and 3.

Client # 1 was admitted to the inpatient detox activity on March 4, 2016 and transferred to the inpatient rehabilitation activity on March 9, 2016. As of the date of the licensing inspection there was no documentation of a psychosocial evaluation.

Client # 3 was admitted to the detox activity on December 4, 2015 and transferred to the inpatient rehabilitation activity on December 10, 2015. As of the date of patient #3's transfer, there was no documentation of a psychosocial evaluation.

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

709.63(a)(2) LICENSURE D & A support plan

709.63. 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: (2) Drug and alcohol support plan.

Observations

Based on a review of four patient records, the facility failed to have a complete record in four of four inpatient nonhospital activities, short term detoxification records reviewed.

Plan of Correction

This facility does not file electronically, a Plan of Correction is on file with the Department of Health.

The findings include:

Four inpatient nonhospital activities, short term detoxification patient records were reviewed on March 9, 2016. The facility failed to document a complete drug and alcohol support plan that reflected the project's efforts to support and motivate the client to seek formal treatment after the detoxification process in patient records, #1, 2, 3, and 4.

Client # 1 was admitted to the inpatient detox activity on March 4, 2016 and transferred to the inpatient rehabilitation activity on March 9, 2016. As of the date of the licensing inspection there was no documentation of a drug and alcohol support plan.

Client # 2 was admitted to the inpatient detox activity on March 7, 2016 and there was no documentation of a drug and alcohol support plan as of the date of the licensing inspection.

Client # 3 was admitted to the inpatient detox activity on December 4, 2015 and transferred to the inpatient rehabilitation activity on December 10, 2015. As of the date of patient #3's transfer, there was no documentation of a drug and alcohol support plan.

Client # 4 was admitted to the inpatient detox activity on October 18, 2015 and transferred to the inpatient rehabilitation activity on October 23, 2015. As of the date of patient # 4's transfer, there was no documentation of a drug and alcohol support plan.

These findings were reviewed with facility staff during the licensing 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.

NEW PERSPECTIVES AT WHITE DEER RUN

3030 CHESTNUT STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 02/10/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on January 24, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, New Perspectives at White Deer Run 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

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.

NEW PERSPECTIVES AT WHITE DEER RUN
3030 CHESTNUT STREET
LEBANON, PA 17042

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/31/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 30-31, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Perspectives at White Deer Run 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

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

Observations
Based on a review of facility records conducted as part of the presubmission process, the facility failed to conduct fire drills for the months of March, September, and October of the year 2016, and the facility records document that the detox unit did not conduct a fire drill in November of the year 2016.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction
The clinical tech supervisor will review with all personnel responsible that we are to conduct monthly fire drills.

The clinical tech supervisor will train all new hires and retrain current employees responsible for conducting fire drills by 5/30/17. These trainings will consist of the correct way to conduct an unannounced fire drill. This includes making sure all buildings are evacuated during the drills.

The Clinical Tech supervisor will observe employees conducting unannounced fire to make sure they are completed correctly and give feedback and guidance when necessary.

The fire drills forms will be kept in a binder where they can be audited on a biweekly basis to ensure fire drills are being conducted and that fire drill forms are being filled out correctly.

The biweekly audit of the fire drill binder will ensure that we are conducting fire drills every month.

Also a reminder will be sent out at the beginning of the month by the technician supervisor to remind staff of the

responsibility to conduct the fire drill.

705.10 (d) (4) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential 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	Plan of Correction
Based on a review of facility records conducted as part of the presubmission process the facility failed to document all of the required information in its fire drill logs.	The Clinical Technician Supervisor will train all staff that are responsible for filling out the fire drill forms by 5/30/17.
The facility failed to document the exit routes used during the evacuation for fire drills held on the following days: 01/26/2017, 12/08/2016, 11/11/2016, 08/12/2016, 07/21/2016 and 06/10/2016.	The Clinical Technician supervisor will audit these forms on within one week of the fired drill being conducted to make sure they are filled out properly which will include the following: date, time, the amount of time it took for evacuation, the exit route used, the number of persons in the facility at the time of the drill, problems encountered and whether the fire alarm or smoke detector was operative.
The facility failed to document wether the fire alarm of smoke detector was operative during the evacuation for fire drills held on the following days: 12/08/2016, and 11/11/2016.	
These findings were reviewed with facility staff as part of the inspection process.	

705.10 (d) (5) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential facility shall: (5) Conduct a fire drill during sleeping hours at least every 6 months.

Observations	Plan of Correction
Based on a review of facility records conducted during the presubmission process, the facility failed to conduct a sleeping hours fire drill from March 1, 2016, through January 31, 2017.	The Clinical Technician Supervisor will make sure all personnel responsible for conducting fire drills be trained on the making sure we conduct during sleeping hour's drills every six months as required by DDAP. This training will be conducted by 5/30/17
These findings were discussed with facility staff as part of the inspection process.	The Clinical Technician Supervisor will ensure this is happening by auditing our fire drill binder biweekly to make sure we are in compliance with the 6 month mark of sleeping hour fire drills.

715.9(a)(2) 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: (2) Verify the individual 's identity, including name, address, date of birth, emergency contact and other identifying data.

Observations	Plan of Correction
Based on a review of patient records the facility failed to ensure that patients were properly screen prior to beginning narcotic treatment.	All staff responsible will be trained by the Nurse Manager on the proper process for screening patients who will be entering the narcotic treatment program by 6/1/2017. This will include the following parameters for screening: verify the individual's identity, including name, address, date of birth, emergency contact and other identifying data. If a client has refused to provide an emergency contact this will be documented by the personnel responsible for conducting this part of the assessment.
Patient #2 was admitted for narcotic treatment on 01/11/2017, and discharged on 01/17/2017, but there was no documentation of an emergency contact for the patient.	

Patient #3 was admitted for narcotic treatment on 01/10/2017, and discharged on 01/15/2017, but there was no documentation that the facility verified the patient's identity.	To ensure this process is occurring correctly five random detox charts will be audited each month by the nurse manager.

These findings were reviewed with facility staff as part of 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.

NEW DIRECTIONS AT COVE FORGE
538 MAIN STREET
JOHNSTOWN, PA 15901

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/18/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 18, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Directions At Cove Forge 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 Staffing Requirements Facility Summary Report forms for all of the facilities within the drug and alcohol treatment project, the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.The findings include:The Staffing Requirements Facility Summary Report forms for the drug and alcohol treatment project's seventeen facilities were reviewed on March 2, 2015. The project employs a total of 106 full-time counselors and counselor assistants. This number of full-time counselors and counselor assistants would require a minimum of 13 full-time clinical supervisors. The project currently employs 8 full-time clinical supervisors, as of March 2, 2015.The findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Director of Quality Management, along with the Executive Director, will ensure there is one full-time clinical supervisor for every eight full-time counselors and counselor assistants. Caseloads will be redistributed by July 1, 2015 so that clinical supervisors who carry a caseload fall within the guidelines of chapter 704.6. Facility directors and clinical supervisors will be re-educated by the Quality Management Department on permissible case load sizes for each level of care. Compliance will be accomplished by the facility director, along with the clinical supervisor(s), monitoring the number of full-time counselors vs. clinical supervisors on a quarterly basis. Completion date July 1, 2015.

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.

NEW DIRECTIONS AT COVE FORGE
538 MAIN STREET
JOHNSTOWN, PA 15901

Survey conducted on 03/24/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on March 24, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Directions At Cove Forge 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

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 a review of client records, the facility failed to obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record in six of ten client records.

The findings include:

Ten client records were reviewed for written, informed and voluntary consents to release information from the client on March 24, 2016. The facility failed to obtain an informed and voluntary consent to release information from the client in client records # 1, 2, 3, 4, 9 and 10.

Based on a review of these records, the facility's consent to release client information form was out of compliance with 42 CFR and State Law 4 Pa. Code 255.5.

The facility's consent to release client information form is a standardized form titled "Authorization to Disclose Healthcare Information". The consent form included the following statement: "I may revoke this authorization at any time. Revocations to this authorization must be in writing". 42 CFR Part 2, Subpart C, subsection 2.31 (a) Required elements, specifies that the following information must be included on the written consent: "(8) A statement that the consent is

Plan of Correction

Program Director will provide training to staff on documenting a consent to release information that is compliant with 4 Pa. Code 255.5.

A line will be added to the consent to release information form to allow for verbal revocation.

All clients will sign consents to release information that are compliant with 42 CFR and 4 Pa. Code 255.5 by 5/31/16.

Program Director will randomly check 5 charts per week for the next 8 weeks to ensure consents are correct.

Quality Director and regional VP are working with corporate to develop a new consent to release information form that will be compliant with State and Federal regulations.

subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it." Therefore, as per 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) the consent to release information form can be revoked by the client at any time and there is no restriction on the manner in which the client may revoke it. The facility failed to adhere to the requirements outlined in the federal confidentiality regulations by requiring the client to revoke the consent to release information in writing.

Client # 1 was admitted into treatment on January 4, 2016. Consent to release information forms for the funding entity, probation officer, physician, hospital, treatment provider and family member were signed by client # 1 on January 4, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form. In addition, the facility allowed for the release of the client's alcohol, drug or substance abuse and mental health records to the funding entity and probation officer. This exceeded the limitations imposed at 4 Pa. Code 255.5.

Client # 2 was admitted into treatment on January 12, 2016. Consent to release information forms for the funding entity, physician, hospital, treatment provider and family member were signed by client # 2 on January 12, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form. In addition, the facility allowed for the release of the client's alcohol, drug or substance abuse and mental health records to the funding entity. This exceeded the limitations imposed at 4 Pa. Code 255.5.

Client # 3 was admitted into treatment on December 26, 2015. A consent to release information form for the funding entity was signed by client # 3 on January 6, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form. In addition, the facility allowed for the release of the client's alcohol, drug or substance abuse and mental health records to the funding entity. This exceeded the limitations imposed at 4 Pa. Code 255.5.

Client # 4 was admitted into treatment on January 13, 2016. Consent to release information forms for the funding entity, probation officer, physician, hospital, treatment provider and family member were signed by client # 4 on January 13, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form. In addition, the facility allowed for the release of the client's alcohol, drug or substance abuse and mental health records to the funding entity and probation officer. This exceeded the limitations imposed at 4 Pa. Code 255.5.

Client # 9 was admitted into treatment on October 23, 2015 and discharged on February 5, 2016. Consent to release information forms for two social service agencies were signed by client # 9 on January 18 and January 27, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form.

Client # 10 was admitted into treatment on December 4, 2015 and discharged on March 3, 2016. Consent to release information forms for two social service agencies were signed by client # 10 on March 2, 2016. The facility failed to adhere to the requirements in 42 CFR, Part 2, Subpart C, subsection 2.31 (a)(8) by restricting the client to a written revocation of the consent to release information form.

The findings were reviewed with facility staff during the licensing 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.

NEW DIRECTIONS AT COVE FORGE
538 MAIN STREET
JOHNSTOWN, PA 15901

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 06/02/2016

INITIAL COMMENTS

This report is a result of complaint investigation conducted on June 2, 2016, by staff from the Program Licensure Division. Based on the findings of the complaint investigation, the allegations made against New Directions at Cove Forge were partially substantiated. New Directions at Cove Forge 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 complaint investigation:

Plan of Correction

709.34 (c) (4) LICENSURE Reporting of unusual incidents
§ 709.34. Reporting of unusual incidents. (c) To the extent permitted by State and Federal confidentiality laws, the project shall file a written unusual incident report with the Department within 3 business days following an unusual incident involving: (4) Event at the facility requiring the presence of police, fire or ambulance personnel.

Observations
The facility failed to file a written incident report with the Department within 3 business days.

Plan of Correction
The Program Director will ensure that unusual incident reports will be completed and filed with the Department of Drug and Alcohol Licensure in accoradance with regulation 709.34.

An onsite complaint investigation was conducted on June 2, 2016. Staff interviews and an incident report was reviewed. Per the incident report, an incident requiring the presence of an ambulance at the facility occurred on May 12, 2016. An incident report was completed; however, it was not provided to the Department.

The Program Director will ensure that unusual incident reports will be filed with the Department of Drug and Alcohol Licensure within three business days of the incident.

These findings were reviewed with facility staff.

709.17(a)(4) LICENSURE Subchapter B.Licensing Procedures.Refusal/rev
709.17. Refusal or revocation of license. (a) The Department may revoke or refuse to issue a license for any of the following reasons: (4) Gross incompetence, negligence or misconduct in the operation of the facility.

Observations
The facility was negligent in ensuring client safety by permitting a staff member to drive the facility van with clients the day after having seizure-like symptoms. The staff member was permitted to drive clients even though the staff member was not examined and cleared by a physician for performing all job duties, specifically driving duties.

Plan of Correction
The driving privileges of the staff member in question have been suspended pending the outcome of a medical evaluation which will take place on 6/16/16. Once the individual has been medically cleared to perform all aspects of their job duties including driving, the driving privileges will be restored.

An ambulance was called on May 12, 2016 for a staff

The Program Director will ensure compliance with the

member having seizure-like symptoms while on duty. The ambulance presented to the facility; however, the staff member was not transported the hospital. The staff member left work immediately after the incident. The next day, the staff member was permitted to drive several clients in the facility's 14-passenger van to appointments 1 1/2 hours away.

facility's HR policy regarding accidents, injuries, or illness that occur in the work place and require all staff to receive medical evaluation and produce documentation of clearance to return to all job duties with or without restrictions.

These findings were reviewed with facility staff.

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.

NEW DIRECTIONS AT COVE FORGE

538 MAIN STREET
JOHNSTOWN, PA 15901

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 12/08/2016

INITIAL COMMENTS

This report is a result of an on-site investigation conducted on November 30, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site investigation, New Directions at Cove Forge 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

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.

NEW DIRECTIONS AT COVE FORGE
538 MAIN STREET
JOHNSTOWN, PA 15901

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/05/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on April 5, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, New Directions at Cove Forge 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

705.10 (a) (1) (i) LICENSURE Fire safety.
705.10. Fire safety. (a) Exits. (1) The residential facility shall: (i) Ensure that stairways, hallways and exits from rooms and from the residential facility are unobstructed.

Observations
The facility failed to ensure that exits from the building were unobstructed based on a physical plant inspection conducted on April 5, 2017 at approximately 10:15 AM.

Plan of Correction
Program Director will place a "No Parking Do Not Block Exit" sign on the outside of the basement door.

The emergency exit from the basement was observed to be obstructed due to a ladder and a vehicle that was parked in front of the door.

Program Director or Lead Technician will monitor the back door area daily for a period of 4 weeks via video camera and visual inspection to ensure a clear egress.

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

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
The facility failed to obtain an informed an voluntary consent from the client prior to the disclosure of information in one of seven client records reviewed during the annual licensing inspection conducted on April 5, 2017.

Plan of Correction
Program Director will conduct staff re-training on the procedure for obtaining informed and voluntary consent and disclosing information following obtaining consent.

The clients name and admission date were released to a judge by fax on February 3, 2017.

Program Director will monitor compliance during random chart audits weekly for 6 weeks.

Client # 1 was admitted into treatment on January 12, 2017.

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

Return to Pennsylvania Department of Health Home Page