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DISCOVERY HOUSE PA

1391 WASHINGTON BOULEVARD
PITTSBURGH, PA 15206

Survey conducted on 10/26/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on October 25-26, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House PA was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.7(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

The facility failed to document that each counselor met the qualifications for the position of counselor.

The personnel and training records were reviewed on October 25, 2016. Employee #6 was found to not meet the qualifications for the position of counselor.

Employee #6 was hired as a counselor on 9/26/16. Employee #6 holds a Bachelor of Arts degree in Psychology; however,

Plan of Correction

This staff member is now a counselor assistant. The Clinical Supervisor will meet with this staff member on a weekly basis for supervision. The Clinical Supervisor will ensure that this staff member completes their required training hours yearly and will complete a 90 day and a 6 month review to discuss their progress. Once they have completed the one year of clinical experience and meet qualifications of a counselor this employee may be promoted to the position of a counselor.

All new counselors hired will meet both the educational and at least 1 year experience qualifications for the position of counselor.

employee #6 has documented only 2 months of the required 1 year clinical experience.

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

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DISCOVERY HOUSE PA
1391 WASHINGTON BOULEVARD
PITTSBURGH, PA 15206

Survey conducted on 03/23/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on March 23, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, Discovery House PA was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

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DISCOVERY HOUSE PA

1391 WASHINGTON BOULEVARD
PITTSBURGH, PA 15206

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/14/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on November 13-14, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House PA was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
704.3(b)

Recruitment and hiring policy will be revised to address the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project.

Clinical Services Department will be responsible for revising the policy

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
709.26

Clinical Service Department will work to revise the Personnel policy to include the utilization of volunteers in the project. Program will review policy revision with all staff in the January all staff meeting.

Completion Date:1/15/2018

709.30 (1) LICENSURE Client rights

§ 709.30. Client rights. The project shall develop written policies and procedures on client rights and document written acknowledgement by clients that they have been notified of those rights. (1) A client receiving care or treatment under

section 7 of the act (71 P. S. § 1690.107) shall retain civil rights and liberties except as provided by statute. No client may be deprived of a civil right solely by reason of treatment.

Observations

The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access to their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

709.30(4)(5)(6)

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

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Unusual Incident policy and procedure will be revised to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site. Policy and procedure will be revised to ensure that the revised policy and procedure of reporting an unusual incident to an entity is in full compliance with State confidentiality laws. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

Completion Date: 1/15/2018

Clinical Services Department will be responsible for revising the policy

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). 709.20(4) states that the receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

715.20(4)

Transfer policy and procedure will be revised to include the project will transfer a patient within 7 days of the patients request to be transferred. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

709.20(4)

Transfer policy and procedure will be revised to include the project shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic program. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

Clinical Service Department will be responsible for revising policy.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations.

Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

715.21(1)(i-iv)

Termination policy and procedure will be revised to include a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

Completion Date: 1/15/2018

Clinical Services Department will revise policy.

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DISCOVERY HOUSE PA
1391 WASHINGTON BOULEVARD
PITTSBURGH, PA 15206

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/05/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on October 5, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the investigation, the allegations against Discovery House were substantiated.

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 deficiencies were identified during this inspection:

Plan of Correction

715.7(b) LICENSURE Dispensing or Administering Staffing

(b) Dispensing time shall be prorated for patient census. There shall be sufficient dispensing staff to ensure that all patients are medicated within 15 minutes of arrival at the dispensing area.

Observations
Staff and patient interviews were conducted on October 5, 2016. The facility failed to ensure that all patients were medicated within 15 minutes of arrival at the dispensing area.

Plan of Correction
Discovery House Pittsburgh recently received an upgrade to our computer system on 11/3/2016. This upgrade should put an end to the freezing and the slowness that we were experiencing.

We have been able to increase the number of nursing hours to ensure that three windows will be opened at all times and four dosing windows will be opened during busier dosing times.

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DISCOVERY HOUSE - NC, INC.
2710 WEST STATE STREET, ROUTE 224
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/04/2018

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on January 3-4, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House-NC, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring
704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
The Recruitment and Hiring Policy will be updated by the Clinical Services Department, and Clinical Director will oversee this process. This policy will be updated by 1/15/2018. Every effort will be made to hire staff persons representative of the population served. Program Staff will continue to work with the Human Resources Business Partner in the recruitment and hiring of appropriate staff of the project.

709.26 (a) (1) LICENSURE Personnel management.
§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Personal Policy will be revised to include the utilization of volunteers in the project. Clinical Services Department will be responsible for updating the policy, and Clinic Director will oversee this process. Policy will be updated by 1/15/18. Clinic Director will review the policy revision with all staff in January All Staff Meeting.

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

Observations
The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook

Plan of Correction
The Clinical Services Department will updated the Client Rights Policy and Procedure to include the client's right to appeal a decision limiting access to records to the director; clients having the right to request the correction of

documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

inaccurate, irrelevant, outdated, or incomplete information in their records; and clients having the right to submit rebuttal data or memoranda to their own record. Clinic Director will oversee this process, and will review the updated policy and procedure with all staff in the January All Staff Meeting.

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Services Department will revise the Unusual Incident Policy and Procedure to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm flood, or other occurrence which closes the facility for more than one day, including if the project requires the presence of police, fire or ambulance personal on site.

Policy and Procedure will also be revised by the Clinical Services Department to ensure that the reporting of an unusual incident to an entity is in full compliance with State Confidentiality laws.

Policy revisions will be completed by the Clinical Services Department by 1/15/18. Clinic Director will review these policy and procedure revisions with all staff in the January 2018 All Staff Meeting.

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 document that a written unusual incident report was filed with the Department for unusual incident reports reviewed on January 3-4, 2018. An ambulance was on site on 11/2/17. The police were on site on 9/21/17. There was no documentation provided that the incidents had been filed with the Department. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

During All Staff Meeting held 1/9/18 the regulation was reviewed in regards to the Unusual Incident Reporting. Everyone is aware if an Unusual Incident occurs and Police or ambulance are called to the facility upon completing the Unusual Incident Report the report needs to be reported to the State that day and a fax transmittal with it to show the Unusual Incident was sent. Program Director will be responsible to see all staff comply with the regulation and see the Unusual Incident reports are sent to the state in a timely manner

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Services Department will revise the Transfer Policy and Procedure to include that the project will transfer a patient within 7 days of the patient's request to be transferred. Clinic Director will review policy and procedure revisions with all staff in January 2018 All Staff Meeting.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Services Department will revise the Termination Policy and Procedure to include that a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program Management will review these policy and procedure revisions with all staff in the January 2018 All Staff Meeting.

715.23(b)(22) LICENSURE Patient records

(b) Each patient file shall include the following information: (22) Aftercare plan, if applicable.

Observations

The facility failed to document an aftercare plan in one of one client record reviewed on January 3-4, 2018. Client # 11 was successfully discharged on October 31, 2017. There was no documentation provided of an aftercare plan. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

The Clinical Supervisor reviewed the citation on Aftercare plans. All clinicians were made aware to complete the after care plan. This was done at the All Staff meeting held on 1/9/18. Clinical Supervisor and lead counselor will do chart audit to ensure compliance.

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DISCOVERY HOUSE - NC, INC.

2710 WEST STATE STREET, ROUTE 224
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/18/2015

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on November 18, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the complaint investigation, the allegations against Discovery House were unable to be substantiated. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

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DISCOVERY HOUSE - NC, INC.
2710 WEST STATE STREET, ROUTE 224
NEW CASTLE, PA 16101

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/06/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on January 5-6, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House - NC, 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

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DISCOVERY HOUSE - NC, INC.

2710 WEST STATE STREET, ROUTE 224
NEW CASTLE, PA 16101

Survey conducted on 01/24/2017

INITIAL COMMENTS

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

Plan of Correction

704.7(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

The facility failed to document that each counselor met the qualifications for the position.

Personnel records were reviewed on January 24-25, 2017. Staff #8 did not meet the qualifications for the position of counselor.

Staff #8 was hired as a counselor on 10/25/16. Staff #8 holds a Bachelor's Degree in Criminal Justice, which meets

Plan of Correction

Staff #8 has signed the counselor assistant job description. She will complete the 6 month of close supervision, which 3 months have been completed since hire she was being closely monitored, these supervision notes have been viewed by the auditor. At the end of the 6 months she will have an evaluation done. On her 1 year anniversary October 25, 2017 if she has been approved she will be made a full counselor. Upon all new counselor hires they will meet the educational and experiential requirements of the state for the position.

the educational requirement; however, staff #8 does not have documentation of the required 1 year clinical experience.

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

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DISCOVERY HOUSE GROUP INC

920 CENTURY DRIVE
MECHANICSBURG, PA 17055

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 12/08/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on December 7-8, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House Group Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations

The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.

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

Plan of Correction

Recruitment and hiring policy will be revised to address the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project.

704.12(a)(6) LICENSURE OutPatient Caseload

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

Observations

The facility failed to ensure that the FTE counselor caseload for counseling in an outpatient program did not exceed 35 active clients.

The Staffing Requirements Facility Summary Report form, completed by the facility, was reviewed on December 7-8, 2017. One counselor's caseload exceeded the 35:1 active clients.

Plan of Correction

Clinic Director is in process of hiring an additional counselor. Currently awaiting finalization of backround checks and initial hire pre-screening requirements.

The Clinic Director will ensure that the counselor caseload ratios will remain 35 to 1 or less by reviewing all counselor caseloads every month for compliance. Clinic Director will make adjustments to counselor caseloads when needed to make sure counselor caseloads do not exceed 35 active Patients.

The counselor's caseload was: 39:1

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations

The facility failed to have written project policies and procedures regarding the utilization of volunteers.

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

Plan of Correction

Personnel policy will be revised to include the utilization of volunteers in the project. Program will review policy revision with all staff in the January all staff meeting.

709.30 (1) LICENSURE Client rights

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

Observations

The facility failed to document written policies and procedures regarding all of the client rights.

The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or

(6) Clients have the right to submit rebuttal data or memoranda to their own record.

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

Plan of Correction

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

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents:

709.34 (a)

(4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day.

(6) Event at the facility requiring the presence of police, fire or ambulance personnel.

(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State

Plan of Correction

Unusual Incident policy and procedure will be revised to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site. Policy and procedure will be revised to ensure that the revised policy and procedure of reporting an unusual incident to an entity is in full compliance with State confidentiality laws. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

confidentiality laws.

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

715.9(a)(4) LICENSURE Intake

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

Observations

The facility failed to document a face-to-face determination of patient's dependency in one of nine patient records reviewed on December 7-8, 2017.

There was no documentation of a face to face determination of dependency in patient record # 5.

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

Plan of Correction

A training was provided to Clinical and Medical staff on 12/14/17. The training focused on having a complete record prior to administration of medication. The Program Physician will meet face to face with all new and transfer Patients to determine and document the Patients dependency. Program Director will complete chart reviews monthly to ensure compliance.

715.10(f) LICENSURE Pregnant patients

(f) The narcotic treatment program shall ensure that each female patient is fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.

Observations

The facility failed to document that each female patient was fully informed of the possible risk to her or her unborn child in four of four patient records reviewed on December 7-8, 2017.

There was no documentation in patient records # 1, 2, 5 and 9 that the female patient was informed of the risks.

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

Plan of Correction

A training has been provided to all clinical staff on 715.10(f) on 12-14-17. Clinical Staff at the time of the initial assessment shall obtain a Pregnant Patient Acknowledgement of Risks. The admitting physician will ensure this is completed prior to ordering the initial dose. This will start on 12-14-17. Clinical supervisor will monitor via clinical and medical chart audits completed on all new admissions.

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures.

The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the

Plan of Correction

Transfer policy and procedure will be revised to include the project will transfer a patient within 7 days of the patients request to be transferred. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

patient and 715.20(4).

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

Transfer policy and procedure will be revised to include the project shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic program. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

715.20(4) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (4) The receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program.

Observations

The facility failed to document that the transferring facility was notified, in writing, of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program in three of five records reviewed on December 7-8, 2017.

Patient records # 3 and 4 were missing the information regarding the initial dose given to the patient.

There was no documentation that the transferring facility was notified of the admittance and initial dose information in patient record # 5.

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

Plan of Correction

The Program Director has provided a training and review of the transfer policy and regulations which require documentation in writing that we notified the transferring narcotic treatment program of the admission date and initial dose. The dispensing staff will complete this task once their initial dose is provided to ensure compliance. The program Director will complete monthly chart reviews of all patients that transfer in and out of Discovery House. This will take effect on 12/14/17.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).

The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives.

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

Plan of Correction

Termination policy and procedure will be revised to include a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

715.23(b)(4) LICENSURE Patient records

(b) Each patient file shall include the following information: (4) The results of an initial intake physical examination.

Observations

The facility failed to document an initial physical examination in one of nine patient records reviewed on December 7-8, 2017.

There was no documentation of a physical in patient record # 5.

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

Plan of Correction

A training was provided to Clinical and Medical staff on 12/14/17. The training focused on having a complete record prior to administration of medication. The Program Physician will meet face to face with all new and transfer Patients to complete an initial physical examination prior to administering medication. Program Director will complete chart reviews monthly to ensure compliance.

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DISCOVERY HOUSE GROUP INC

920 CENTURY DRIVE
MECHANICSBURG, PA 17055

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 04/27/2017

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on April 27, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the complaint investigation, the allegations against Discovery House Group CC, Inc., were substantiated. However, no deficiencies were identified during this investigation and no plan of correction is required.	**Plan of Correction**

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DISCOVERY HOUSE GROUP INC

920 CENTURY DRIVE
MECHANICSBURG, PA 17055

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 licensure renewal inspection and methadone monitoring inspection conducted on December 6 - 8, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House Group 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

704.5(c) LICENSURE Qualifications for Proj/Fac Dir

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

Observations

The facility failed to ensure that the facility director met the qualification requirements for the position of facility director.

Staff Person #2 was promoted to facility director on 8/22/16, but the staff person does not have a degree in one of the qualifying areas for facility director.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The Project Director will ensure that the Facility Director meets the qualification requirements for the position. Regional Director will temporarily take over facility director duties until the current facility director acquires the required education. This will take effect 1/3/17.

704.11(e)(2) LICENSURE Annual Trng Req-Clin Sup

704.11. Staff development program. (e) Training requirements for clinical supervisors. (2) Each clinical supervisor shall complete at least 12 clock hours of training annually in areas such as: (i) Supervision and evaluation. (ii) Counseling techniques. (iii) Substance abuse trends and treatment methodologies in the field of addiction. (iv) Confidentiality. (v) Codependency/Adult Children of Alcoholics (ACOA) issues. (vi) Ethics. (vii) Interaction of addiction and mental illness. (viii)

Cultural awareness. (ix) Sexual harassment. (x) Developmental psychology. (xi) Relapse prevention. (xii) Disease of addiction. (xiii) Principles of Alcoholics Anonymous and Narcotics Anonymous.

Observations

The facility failed to ensure that all of the staff completed all of the required training in the previous training year.

Staff Person #2 was promoted to clinical supervisor on 02/24/2010, and was a clinical supervisor during the 2015 training year, but the staff person only completed 6 hours of annual training in the 2015 training year.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The Facility Director will ensure that all staff complete the required annual training. The facility Director and Clinical Supervisor will review training attended by all staff quarterly and address any deficiencies with staff. This will begin 1/3/17.

705.24 (3) LICENSURE Bathrooms.

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

Observations

The facility failed to ensure that the hot water temperature for the facility bathrooms were no higher that 120 degrees Fahrenheit.

The water temperature for both the lobby bathroom, and the staff bathroom, were tested at 134 degrees Fahrenheit.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The facilities hot water temperature was adjusted on 12/28/16, to ensure that the water temperature is 120 degrees Fahrenheit. Facility Director will check water temperature quarterly as part of internal health and safety inspections.

705.28 (d) (4) LICENSURE Fire safety.

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

Observations

The fire drill record for the fire drill conducted on January 5, 2016, does not document the exits used to evacuate.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

Training was provided by the Program Director to the Health and Safety Captain on Fire Drill procedures. The training focused on completing drills using alternate exits for evacuation and documenting the exits used in the fire drill record. Program Director will monitor by quarterly reviews during the Health and Safety meetings which are held quarterly. This was completed on 1/5/17.

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

The facility failed to document all of the required screening information in determining patient eligibility for admission to narcotic treatment.

Patient 18 was admitted for narcotic treatment on 3/07/16, but the facility did not have documented identification for the

Plan of Correction

A training was provided to Clinical staff on 1/5/17. The training focused on the completion of releases of information and making sure en emergency release is completed for all Patients being admitted. Program Director will complete chart reviews monthly to ensure compliance. The primary counselor will photo copy patient photo ID and scan into the electronic record at the time of initial assessment. Clinical supervisor will ensure this is completed by utilizing the

patient.

Clinical and Medical Chart audit to ensure this process has been completed.

Patient 11 was admitted for narcotic treatment on 4/13/16, but the facility did not have documentation of an emergency contact for the patient.

Patient 13 was admitted for narcotic treatment on 5/13/16, but the facility did not have documentation of an emergency contact for the patient.

This was reviewed with the facility staff during the licensing process.

715.10(f) LICENSURE Pregnant patients

(f) The narcotic treatment program shall ensure that each female patient is fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.

Observations

Patient #11 is a female patient who was admitted for narcotic treatment on 4/13/16, and was an active patient at the time of the onsite inspection. but the facility did not inform the patient of the potential risks of narcotic agents on unborn children.

This was reviewed with the facility staff during the licensing process

Plan of Correction

A training has been provided to all clinical staff on 715.10(1-5) on 1/5/17. Clinical Staff at the time of the initial assessment shall obtain an informed, voluntary, written consent to treatment, which includes the potential risks of narcotic agents on unborn children. The admitting physician will ensure this is completed prior to ordering the initial dose. Clinical supervisor will monitor via clinical and medical chart audits completed on all new admissions.

715.13(b) LICENSURE Patient identification

(b) A narcotic treatment program shall maintain onsite a photograph of each patient which includes the patient 's name and birth date. The narcotic treatment program shall update the photograph every 3 years.

Observations

The facility failed to maintain an on-site photograph of each patient in two of six buprenorphine patient records reviewed during the annual licensing and methadone monitoring inspection conducted on December 6 - 8, 2016. Patient records #2 and #6 did not have a photo.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The primary counselor will photo copy patient photo ID and scan into the electronic record at the time of initial assessment. Clinical supervisor will ensure this is completed by utilizing the Clinical and Medical Chart audit to ensure this process has been completed.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

During the annual licensing and methadone monitoring inspection conducted on December 6 - 8, 2016, the facility failed to provide a complete initial and monthly drug screening urinalysis in buprenorphine patient records, # 1,2 3, 4, 5, and 6. The facility completes rapid screen dipstick urine tests, and does not send the results to the lab. A complete drug screen includes receiving the results from the CLIA and Department of Health approved laboratory.

Plan of Correction

The facility nursing staff will collect and send all initial and random monthly drug screens to Clinical Science Laboratory for testing. This will begin 1/3/17.

This was reviewed with the facility staff during the licensing process.

715.19(1) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (1) A narcotic treatment program shall provide each patient an average of 2.5 hours of psychotherapy per month during the patient 's first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations

During the annual licensing and methadone monitoring inspection conducted on December 6 - 8, 2016, the facility failed to document 2.5 hours of psychotherapy in the patients first two years for buprenorphine patient records # 2, 3, 4, 5 and 6.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

A training was held by the clinical supervisor on 1/5/17 to ensure that each patient receives a minimum of 2.5 hours of psychotherapy per month. The training focused on ensuring individualized psychotherapy services are being provided, as well as documented in the treatment plan. Counseling hours and individualized services will be reviewed with counselors during supervision to address deficiencies and create action plans. This will be monitored by the clinical supervisor and the Program director through chart audits to ensure compliance. This plan of action will take place 1/3/17.

715.20(1) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (1) The transferring narcotic treatment program shall transfer patient files which include admission date, medical and psychosocial summaries, dosage level, urinalysis reports or summary, exception requests, and current status of the patient, and shall contain the written consent of the patient.

Observations

The facility failed to send all of the required documentation for patients transferring to another narcotic treatment program.

Patient #15, a patient receiving narcotic treatment, was transferred from the facility to another narcotic treatment program on 11/21/2016, but there was no documentation that the patient ' s psychological summary and a consent to release information were sent to the receiving program.

Patient #16, a patient receiving narcotic treatment, was transferred from the facility to another narcotic treatment program on 5/12/2016, but there was no documentation that the patient ' s psychological summary and a consent to release information were sent to the receiving program.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The Clinical Supervisor provided a training on 1/5/17 to all clinical staff on what files are to be sent to facilitate a transfer and how to document once completed. The training will also focus on the released of information and need to include all items required to be sent. Documentation will be placed in the patient chart via scanning of the material sent and fax transmittal. The clinical supervisor and Program Director will monitor through monthly chart audits to ensure compliance.

715.20(4) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (4) The receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program.

Observations

The facility failed to send all of the required information to narcotic treatment programs for patients that transferred in from those other narcotic treatment programs.

Plan of Correction

The Program Director provided a training 1/5/17 on the transfer policy and regulations which require documentation in writing that we notified the transferring narcotic treatment

Patient #13 was transferred in for narcotic treatment on 5/13/16, from another narcotic treatment program, but there was no documentation that the receiving program sent the transferring program documentation of the patient ' s admission to the receiving program and initial narcotic dose at the receiving program.

Patient #14 was transferred in for narcotic treatment on 2/19/16, from another narcotic treatment program, but there was no documentation that the receiving program sent the transferring program documentation of the patient ' s admission to the receiving program and initial narcotic dose at the receiving program.

This was reviewed with the facility staff during the licensing process.

program of the admission date and initial dose. The dispensing staff will complete this task once their initial dose is provided to ensure compliance. The program Director will complete monthly chart reviews of all patients that transfer in and out of Discovery House.

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

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

Observations

The facility failed to document that the medical director reviewed, signed and dated the annual evaluation in two of three patient records reviewed during the annual licensing and methadone monitoring inspection conducted on December 6 - 8, 2016. Methadone patient records # 8 and 10, included annual evaluations, but they were not reviewed, signed and dated by the medical director.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

The Facility Director and Medical Director, met on 1/6/17 to ensure that he reviews, signs and dates all annual clinical evaluations. This will take effect 1/6/17. Clinical Supervisor will review twice a month to ensure the medical director is reviewing and signing the annual clinical evaluations. Facility Director met with counselors on 1/5/17, counselors will use our internal message system to alert the Medical Director that they have annual clinical evaluations for his review.

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

During the annual licensing and methadone monitoring inspection conducted on December 6 - 8, 2016, the facility failed to document the treatment plans were developed with the clients in records # 1, 4, 5, & 6.

This was reviewed with the facility staff during the licensing process.

Plan of Correction

A training was held on 1/5/17 by the clinical supervisor with all clinical staff, to ensure that treatment plans are developed, reviewed and completed with the Patient and that this is documented in each Patient's chart. This will take effect 1/3/17. Clinical Supervisor will complete monthly clinical chart audits and monthly clinical quality chart reviews to ensure compliance.

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DISCOVERY HOUSE, INC.
2755 PHILMONT AVENUE, SUITE 115
HUNTINGDON VALLEY, PA 19006

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 03/01/2018

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on February 27 - March 1, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
Recruitment and hiring policy will be revised to address the recruitment and hiring of staff persons who are appropriate to the population served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project. Clinical Services Department will be responsible for revising the policy.

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
The facilty failed to have a full time clinical supervisor for every eight full-time counselors. At the time of the inspection, the facility had 8 full time counselors and one part-time counselor. There is a clinical supervisor (staff #3) employed at the Facility; however, as documented on the Staffing Requirements Facility Staffing report, she carries a caseload of 10 patients, with 7 of them attending counseling at least twice per month. Her hours are split evenly between counseling and clinical supervision.These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Clinical Supervisor will reduce and then maintain the reduced patient caseload to ensure she meets the State of PA standard for a full time Clinical Supervisor.

The Director is responsible for ensuring the Clinical Supervisor meets the reduced patient caseload and maintains this status. The Director will audit the caseload monthly to ensure the Clinical Supervisor maintains compliance.

The reduced caseload will go into effect by April 1, 2018

704.6(e) LICENSURE Supervisory Meetings

704.6. Qualifications for the position of clinical supervisor. (e) Clinical supervisors are required to participate in documented

monthly meetings with their supervisors to discuss their duties and performance for the first 6 months of employment in that position. Frequency of meetings thereafter shall be based upon the clinical supervisor's skill level.

Observations
The current clinical supervisor was promoted to her position on January 2, 2017. There was no documentation of the monthly meetings with the facility director for the first 6 months of employment in that position.These findings were reviewed with facility staff during the licensing process.

Plan of Correction
If or whenever a new Clinical Supervisor is hired, the Director will document the monthly meetings for the first 6 months of employment in that position.

The Director is responsible for ensuring the monthly meeting documentation occurs for a minimum of the first 6 months of employment for a Clinical Supervisor.

This practice is effective immediately, March 12, 2018.

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
Clinical Service Department will work to revise the Personnel Policy to include the utilization of volunteers in the project. Program will review policy revision with all staff in the April Staff Meeting.

Clinical Service Department is responsible for the policy development.

709.30 (1) LICENSURE Client rights

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

Observations
The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
Clinical Services Department is responsible for the Client Rights Policy and procedure will be revised to include the client's right to appeal a decision limiting access to records to the Director: Client having the right to request the correction of inaccurate, irrelevant, outdated, or incomplete information in their records; clients have the right to submit rebuttal data or memorandum to their own record. Program management will review policy and procedure revision with all staff at the April 2018 staff meeting.

709.32 (c) (1) LICENSURE Medication control

§ 709.32. Medication control. (c) The project shall have and implement a written policy and procedures regarding all medications used by clients which shall include, but not be limited to: (1) Administration of medication, including the documentation of the administration of medication: (i) By individuals permitted to administer by Pennsylvania law. (ii) When self administered by the client.

Observations
The facilty failed to document the inspection of the medication storage area at least quarterly.There was no documentation of inspection of the medication storage area for the 2017 calendar year.These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Nurse Manager will utilize the "Inspection of Dosing Area" Form monthly to ensure there is documentation to support the inspection of the medication storage area.

The Director will conduct monthly audits to ensure the form is completed monthly.

This practice goes into effect immediately. The Inspection was completed on March 9, 2018 and the Director co-signed the Inspection form.

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Unusual Incident Policy and procedure will be revised to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood, or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site.

Policy and procedure will be revised to ensure that the policy and procedure of reporting an unusual incident to an entity is in full compliance with State confidentiality laws.

Program Management will review policy and procedure revisions with all staff at the April 2018 Staff Meeting.

Clinical Services Department is responsible for revising the policy.

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Transfer policy and procedure will be revised to include: the project will transfer a patient within 7 days of the patients request to transfer.

Program Management will review the revised policy and procedure with all staff at the April 2018 Staff Meeting.

Transfer policy and procedure will be revised to include: the project shall document in writing that the project notified the transferring narcotic treatment program of the admission and the date of the initial dose given to the patient by the receiving narcotic program.

Program Management will review the policy and procedure revisions with all staff at the April 2018 staff meeting.

The Clinical Services Department is responsible for policy revisions.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

Plan of Correction

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.	Termination Policy and procedure will be revised to include: a patient may be involuntarily discharged from the project if the patient failed to follow treatment plan objectives. Program Management will review policy and procedure revisions with all staff at the April 2018 Staff Meeting. Clinical Services Department is responsible for the policy revision.

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DISCOVERY HOUSE, INC.

2755 PHILMONT AVENUE, SUITE 115
HUNTINGDON VALLEY, PA 19006

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/26/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on January 24-26, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House 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 as part of the presubmission process and during the onsite inspection, the facility failed to ensure that all staff persons received the required communicable disease training within the required time frames.

Staff Person #4 was hired as a counselor on 7/13/2015, but at the time of the onsite inspection, the facility did not have documentation that the staff person had the required 4 hours of TB/STD training.

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

Plan of Correction

0067: Staff Person #4 received the Certificate of Completion for Communicable Diseases: Tuberculosis, Viral Hepatitis, Sexually Transmitted Diseases from The Center for Addiction Studies and Research on January 26, 2017 for 30 education and training clock hours.

The Clinical Supervisor or designee is tasked to ensure all training hours are completed annually while ensuring the TB/STD & HIV/AIDS training hours are completed within the State of PA guidelines.

The Clinical Supervisor or designee will monitor the completion of the State of PA required TB/STD & HIV/AIDS training by reviewing all clinical and non-clinical new hire employee/s record at 9 months of employment to ensure the TB/STD & HIV/AIDS training is completed.

The Facility Director is responsible for ensuring all training hours are completed annually and the State of PA required trainings are completed within the State of PA time frames.

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 the facility records conducted as part of the presubmission process and during the onsite inspection, the facility failed to ensure that there was at least one staff person certified in first aid scheduled for all hours of operation.

The facility had no regularly scheduled staff person with documented certification in first aid.

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

Plan of Correction

0069: The Nurse Manager enrolled in a CPR/First Aid/AED Train the Trainer Class at Holy Redeemer Hospital scheduled for March 25, 2017. The Nurse Manager will conduct a staff CPR/First Aid clinic training on Wednesday, April 5, 2017 for staff First Aid and CPR. The Nursing Team, Director, and PA-C will complete their First Aid Certification by March 20, 2017.

The Nurse Manager is responsible for training staff members for CPR & First Aid upon completion of her train the trainer course.

The Director is responsible for ensuring there are staff members certified in First Aid to cover all hours of operation and the Nurse Manager attends the scheduled Train the Trainer course.

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 staff interviews conducted during the onsite inspection, the facility failed to keep the equipment of the facility in good repair.

The facility has an exception to use an alternate means to conduct fire drills instead of setting off the fire alarm. The alternate means the facility normally uses to conduct fire drills is its public announcement system, but the public announcement system is not operational forcing the facility staff to go door to door within the facility to conduct fire drills.

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

Plan of Correction

P179: The Information Technology Team corrected the intercom problem. The intercom system was tested on February 17, 2017 & February 24, 2017. The clinic Health & Safety Captain will test the intercom system monthly and report its malfunctioning to the Director. The Director will sign the Fire Drill Form which will indicate the intercom status. The Director will work with the Information Technology Team if there is a malfunction to immediately correct the issue.

The Safety Captain or designee will conduct a monthly system check and document the test result on the Monthly Fire Drill Report.

The Director is responsible for ensuring the system is working at all times.

705.28 (d) (1) LICENSURE Fire safety.

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

Observations

Based on a review of facility records conducted as part of the presubmission process, and staff interviews conducted during the onsite inspection, the facility failed to conduct monthly fire drills.

The facility did not conduct fire drills during the months of July, August and November of the year 2016.

Plan of Correction

P273: The Health and Safety Captain will conduct a fire drill monthly. The Facility Director will counter sign the document upon the completion of the monthly Fire Drill Report. This process will begin with the March 2017 Fire Drill. The Health and Safety Captain will develop a Fire Drill Calendar and place the calendar in the Health and Safety Binder which is secured in the Health & Safety Captain's office. The Health & Safety Captain or designee is the only person with access to the binder.

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

The Health and Safety Captain or Committee designee is responsible for conducting the Fire Drill monthly.

The Director is responsible for ensuring the Fire Drill is conducted monthly.

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 facility records conducted during the onsite inspection the facility failed to update treatment plans at least every 60 days in 4 of 9 patient records reviewed.

Patient #2 was admitted for treatment on 05/09/2016, and was an active patient at the time of the onsite inspection. The patient's individualized treatment plan was completed on 05/20/2016, but the treatment plan was not updated until 08/01/2016.

Patient #4 was admitted for treatment on 01/04/2016, and was discharged on 10/25/2016. The patient's individualized treatment plan was completed on 02/01/2016, and was updated on 03/10/2016, and 05/04/2016, but was not updated again until 08/01/2016.

Patient #6 was admitted for treatment on 09/14/2011, and was discharged 10/18/2016. The patient had a treatment plan update completed 07/14/2016, but the next treatment plan updated was not completed until 09/27/2016.

Patient #10 was admitted for treatment on 08/17/2016, and was an active patient at the time of the onsite inspection. The patient's individualized treatment plan was completed on 09/21/2016, but the treatment plan was not updated until 12/06/2016.

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

Plan of Correction

1883: The Clinical Supervisor or designee will audit the electronic medical record utilizing the Services Due by Type Report (Treatment Plans) 2x's per month to ensure the treatment plans are updated as required by the State of PA Regulations. The Peer Supervision Group will also audit the charts monthly at their meeting to identify compliance issues, if they exist and document deficiency's on the Peer Supervision Form.

The Clinical Supervisor or designee is responsible for conducting the audits and ensuring the Treatment Plans are updated as required by State of PA Regulations.

The Director is responsible for ensuring the audits are done bi-monthly and the treatment plans are updated as required by the State of PA Regulations.

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DISCOVERY HOUSE, INC.
2755 PHILMONT AVENUE, SUITE 115
HUNTINGDON VALLEY, PA 19006

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/10/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on November 9-10, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House, 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 personnel and training records, the facility failed to provide documentation of HIV/AIDS and TB/STD training in one of five applicable records reviewed

The findings include:

Five personnel records which required documentation of mandatory communicable disease training were reviewed on November 9-10, 2015. The facility failed to provide documentation of HIV/AIDS and TB/STD training for employee #1.

Employee #1 was hired June 7, 2011 as the Facility Director. This employee was required to obtain six hours of HIV/AIDS and 4 hours of TB/STD training by June 7, 2012. Employee #1 failed to provide certification of this training as of the date of the inspection.

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

Plan of Correction
The Facility Director will complete the mandatory 6 hours of HIV/AIDS training and 4 hours of TB/STD training by March 31, 2016.

The Facility Director will ensure that training hours are complete annually.

The Facility Director is responsible for ensuring the training is complete.

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DISCOVERY HOUSE HA

99 SOUTH CAMERON STREET
HARRISBURG, PA 17101

Survey conducted on 12/06/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on December 5-6, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House HA was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations

The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

Recruitment and hiring policy will be revised to address the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project.

Completion Date:

1/15/2018

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 a counselor received at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics within the first year of employment in one of one personnel record reviewed on December 5-6, 2017.Personnel record #8 was hired as a counselor on September 26, 2016. There was no documentation that the counselor had completed the 4 hours of tuberculosis sexually transmitted diseases and other health related topics, due by September 26, 2017, as of December 6, 2017. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

STD,TB,HIV/AIDS training will be added to the new staff hire checklist to ensure all staff will be scheduled and trained within the first year of employment. The Clinical Director will review the checklist within the first 30 days of employment and monthly after to ensure training compliance.

704.12(a)(6) LICENSURE OutPatient Caseload

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

Observations

The facility failed to ensure that the FTE counselor caseload for counseling in an outpatient program did not exceed 35 active clients. The Staffing Requirements Facility Summary Report form,completed by the facility, was reviewed on December 5-6, 2017. Five counselors caseloads exceeded the 35:1 active clients.The five counselors caseloads were: 74:1, 37:1, 37:1, 42:1 and 42:1. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project and to ensure that the FTE counselor caseload for counseling in an outpatient program does not exceed 35 active patients. Program Director will be responsible for coordinating with Human Resources Business Partners for recruitment. Three qualified counselors have been interviewed and offered FTE positions to fulfill the 35:1 counselor patient ratio. Program Director will continue to actively interview and maintain a qualified pool of potential counselors to assure facility maintains a 35:1 ratio.

Clinical Supervisor, Senior Counselor, and Clinical Service Coordinator/CTC Division will meet monthly to review caseloads to assure facility maintains 35:1 ratio is met.

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations

The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Personnel policy will be revised to include the utilization of volunteers in the project. Program will review policy revision with all staff in the January all staff meeting.

709.30 (1) LICENSURE Client rights

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

Observations

The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

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

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State

Plan of Correction

Unusual Incident policy and procedure will be revised to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site. Policy and procedure will be revised to ensure that the revised policy and procedure of reporting an unusual incident

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

to an entity is in full compliance with State confidentiality laws. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

715.9(a)(1) 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: (1) Verify that the individual has reached 18 years of age.

Observations

The facility failed to verify that the individual had reached 18 years of age in four of nine patient records reviewed on December 5-6, 2017, There was no documentation that verified the age of the patient in patient records # 1, 10, 11 and 12. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Program Director will provide a training to clinical staff addressing the appropriate screening to determine eligibility for admission. The verification process will include the individual's identity, including name, address, date of birth, emergency contact, and other identifying data. The Clinical Supervisor will monitor admission process to assure accuracy before individual is admitted into program quarterly.

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

The facility failed to verify the individual's identity in four of nine patient records reviewed on December 5-6, 2017, There was no documentation that verified the identity of the patient in patient records # 1, 10, 11 and 12. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Program Director provided a training to clinical staff addressing the appropriate screening to determine eligibility for admission. The verification process will include the individual's identity, including name, address, date of birth, emergency contact, and other identifying data. The Clinical Supervisor will monitor admission process to assure accuracy before individual is admitted into program quarterly.

715.10(f) LICENSURE Pregnant patients

(f) The narcotic treatment program shall ensure that each female patient is fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.

Observations

The facility failed to document that each female patient was fully informed of the possible risk to her or her unborn child in two of nine patient records reviewed on December 5-6, 2017. Thirteen patient records were reviewed. Ten records were reviewed as methadone patients and three were reviewed as buprenorphine waiver patients.There was no documentation in patient records # 5 and 15 that the female patient was informed of the risks. These finding were reviewed with facility staff during the licensing inspection.

Plan of Correction

The Patient Pregnant Acknowledgement of Risks Form has been added to the intake process checklist. Counselors will be responsible for assuring new pregnant female patients are educated on the risks of MAT and pregnancy. New patients will review and acknowledge the information with their signature on the form. Clinical Supervisor will review new admissions intake process checklist 24 hours after admission for compliancy. Program Director will review new admission process quarterly to assure compliancy.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

The facility failed to document a complete initial drug-screening urinalysis for each prospective patient in six of thirteen patient record reviewed on December 5-6, 2017. Thirteen patient records were reviewed. Ten were reviewed as methadone patients and three were reviewed as buprenorphine waiver patients. Patient records # 1, 3, 4, 11, 12 and 15 did not document a completed drug screen prior to admittance. Patient # 1 was admitted and dosed on July 19, 2017. The initial drug-screening urinalysis results were documented on July 20, 2017. Patient # 3 was admitted and dosed on March 20 , 2017. There was no reported date on the initial drug-screening urinalysis. Patient # 4 was admitted and dosed on January 4, 2017. The initial drug-screening urinalysis results were documented on January 6, 2017. Patient # 11 was admitted and dosed on February 1,

Plan of Correction

The medical staff at this facility will complete all urine drug screening and send to an approved laboratory for testing and receiving results. This will include initial and monthly drug screening urinalysis in the bupernorphine program. Counselor will be required to assure patient has urinalysis testing during the assessment process to be sent to the approved laboratory the day of assessment. Nurse Manager will be responsible to assure patients urinalysis results are present with a report date before patient will be admitted into program. Clinical Supervisor will review new admission records within 24hours after admission and monthly thereof for compliancy.

2017. The initial drug-screening urinalysis results were documented on February 19, 2017. Patient # 12 was admitted and dosed on December 16, 2016. The initial drug-screening urinalysis results were documented on December 20, 2016. Patient # 15 was admitted on January 25, 2017 and received a script for Suboxone on January 30, 2017. There was no date of report documented on the initial drug-screening urinalysis. These findings were reviewed with facility staff during the licensing process.

715.14(d) LICENSURE Urine testing

(d) A narcotic treatment program shall ensure that a laboratory that performs the testing required under this section shall be in compliance with applicable Federal requirements, specifically the Clinical Laboratory Improvement Amendments of 1998 (42 U.S.C.A. §§ 201 note, 263 and 263a notes), and State requirements, specifically the Pennsylvania Clinical Laboratory Act (35 P.S. §§ 2151-2165) and Chapter 5 (relating to clinical laboratories).

Observations

The facility failed to ensure that the laboratory that performed the testing complied with the Clinical Laboratory Improvement Amendments of 1998 as reviewed on December 5-6, 2017. The facility did not provide documentation that the laboratory used was CLIA approved. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

The facility will ensure the laboratory that performs the urinalysis testing is in compliance with the Clinical Laboratory Improvement Amendments of 1988. The facility will secure documentation that the laboratory is CLIA approved. The Program Director will be responsible for ensuring the laboratory that performs the urinalysis testing is in compliance with the Clinical Laboratory Improvement Amendments of 1988.

715.19(3) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (3) After 4 years of treatment, a narcotic treatment program shall provide each patient with at least 1 hour of group or individual psychotherapy every 2 months. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations

The facility failed to provide a patient with at least 1 hour of group or individual psychotherapy every 2 months in one of two patient records reviewed on December 5-6, 2017. Patient # 8 requires 1 hour of group or individual psychotherapy every 2 months. The last two documented sessions were May 24, 2017 and November 23, 2017. No sessions were documented for July or September 2017. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Program Director will provide a training to clinical staff addressing the requirements for individualized psychotherapy services. The requirements would consist of 2.5 hours of psychotherapy per month during the patient's first 2 years, 1 hour of individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing patient assessments. The Program Director and Clinical Supervisor will review for compliance quarterly.

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Transfer policy and procedure will be revised to include the project will transfer a patient within 7 days of the patients request to be transferred. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent

from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Termination policy and procedure will be revised to include a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

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99 SOUTH CAMERON STREET
HARRISBURG, PA 17101

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Survey conducted on 12/16/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on December 13-15, 2016, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House HA was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

705.28 (c) (3) LICENSURE Fire safety.

705.28. Fire safety. (c) Fire extinguishers. The nonresidential facility shall: (3) Ensure fire extinguishers are inspected and approved annually by the local fire department or fire extinguisher company. The date of the inspection shall be indicated on the extinguisher or inspection tag. If a fire extinguisher is found to be inoperable, it shall be replaced or repaired within 48 hours of the time it was found to be inoperable.

Observations

Based on an examination for the fire extinguisher tags and staff interviews conducted during the onsite inspection, the facility failed to ensure that all of the fire extinguishers in the facility were inspected at least once a year.

The inspection tags for all of the fire extinguishers in the facility including the extinguisher right next to the facility director's office and the fire extinguisher right outside of the staff bathroom were all marked as last inspected in March of 2015.

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

Plan of Correction

The fire extinguishers have been inspected 12/19/2016 by the fire extinguisher company to be found operable. The fire extinguisher tags have been updated. The fire extinguisher company has been scheduled for inspection on a yearly basis. The Health and Safety Checklist will include inspection updates of fire extinguishers to ensure compliance in the future.

Completion Date: 12/19/2016

705.28 (c) (4) LICENSURE Fire safety.

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

Observations

The facility failed to ensure that all new staff persons received the required fire extinguisher training.

Staff Person #6 was hired on 9/26/2016, but the facility did not have documentation that the staff person received training in the use of fire extinguishers.

Plan of Correction

Fire extinguisher training checklist has been added for new staff employees. An employee signature acknowledgement 16.1 Health & Safety , v. 16.1 form has been established and an employment checklist will be completed on the first day of employment by the Program Director or other appropriate CTC Division staff. The Program Director will review the checklist for compliancy quarterly.

Staff Person #7 was hired on 10/10/2016, but the facility did not have documentation that the staff person received training in the use of fire extinguishers.

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

Staff #6 and staff #7 have attended the the health & safety training on the use of fire extinguishers 12/19/2016 and has signed off on having received the training.

Completion Date: 12/19/2016

705.28 (d) (1) LICENSURE Fire safety.

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

Observations

The facility failed to conduct unannounced fire drills in the months of February 2016 and July 2016.

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

Plan of Correction

The Health and Safety Captain checklist has been implemented for conducting monthly fire drills to ensure all required documentation is included within the fire drill records. The Health and Safety Captain will conduct-unannounced fire drills every month and document accordingly. The Program Director and/or Health and Safety Team will review the checklist to ensure compliance on a quarterly basis.

Completion Date: 12/19/2016

705.28 (d) (4) LICENSURE Fire safety.

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

Observations

The facility failed to include all of the required documentation in its fire drill records.

The fire drill log for the fire drill conducted on 01/08/2016 did not document the evacuation routes used or the evacuation time of the drill.

The fire drill log for the fire drill conducted on 03/18/2016, 04/25/2016, and 6/25/2016 did not document the evacuation routes used in the drill.

The fire drill log for the fire drill conducted on 08/12/2016 did not document the evacuation routes used, the evacuation time, or the number of people evacuated in the drill.

The fire drill log for the fire drill conducted on 09/22/2016 and 10/12/2016 did not document the evacuation routes used in the drill.

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

Plan of Correction

The Health and Safety Captain checklist has been implemented for conducting monthly fire drills to ensure all required documentation is included within the fire drill records. The fire drill records will include the date, time, evacuation time, exit route used, number of persons in the facility at the time of drill, problems encountered, and whether the smoke detector or fire alarm was operative. The fire drill will be reviewed monthly by Health and Safety Captain and submitted to Program Director to ensure compliance quarterly.

Completion Date: 12/19/2016

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 onsite inspection, the facility failed to document all of the required information during the screening process in 3 of 8 records reviewed during the onsite inspection.

Patient #2 was admitted for narcotic treatment on 02/29/2016. The facility did not have documentation verifying the patient's identity.

Patient #4 was admitted for narcotic treatment on 01/27/2016. The facility did not have documentation of an emergency contact person for the patient.

Patient #13 was admitted for narcotic treatment on 07/26/2016. The facility did not have documentation of an emergency contact person for the patient.

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

Plan of Correction

Program Director provided a training to clinical staff on 1/5/17 addressing the appropriate screening to determine eligibility for admission. The verification process will include the individual's identity, including name, address, date of birth, emergency contact, and other identifying data. This will take place effective 1/5/17. The Clinical Supervisor will monitor admission process to assure accuracy before individual is admitted into program quarterly.

Completion Date: 1/6/17

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Based on staff interviews and a review of patient records conducted during the onsite inspection, the facility failed to provide a complete initial and monthly drug screening urinalysis in buprenorphine patient records, # 10, 11, 12 and 13. The facility completes rapid screen dipstick urine tests and does not send the results to the lab. A complete drug screen includes receiving the results from the CLIA and Department of Health approved laboratory.

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

Plan of Correction

The medical staff at this facility will complete all urine drug screening and send to an approved laboratory for testing and receiving results. This will include initial and monthly drug screening urinalysis in the bupernorphine program.

Plan of Correction: 12/17/2016

715.19(1) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (1) A narcotic treatment program shall provide each patient an average of 2.5 hours of psychotherapy per month during the patient 's first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations

The facility failed to provide the required individual psychotherapy hours in 2 of 10 patient records reviewed during the onsite inspection.

Patient #10 was admitted for narcotic treatment on

Plan of Correction

Program Director provided a training to clinical staff on 1/10/2017 addressing the requirements for individualized psychotherapy services. The requirements would consist of 2.5 hours of psychotherapy per month during the patient's first 2 years, 1 hour of individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing patient assessments. The effective date is 1/10/17. The

03/08/2016. The patient received 0 hours of individual psychotherapy in the months of July, August, September and October of the year 2016.

Patient #13 was admitted for narcotic treatment on 07/26/2016. The patient received 0 hours of individual psychotherapy in the months of September and October of the year 2016.

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

Program Director and Clinical Supervisor will review for compliance quarterly.

Completion Date: 1/10/17

715.23(b)(25) LICENSURE Patient records

(b) Each patient file shall include the following information: (25) Documentation of patient grievances.

Observations

Based on staff interviews and a review of the facility records during the onsite inspection, the facility does not document patient grievances.

The last documented patient grievance was dated 08/05/2015.

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

Plan of Correction

The Program Director has developed a Grievance Binder to store all patient grievances. All patients will continue to have access to grievance forms located at the reception desk. There is a secured mailbox in which the patient grievances will be placed upon completion. The Program Director will check the mail box daily and address any grievances within 24 hours of receiving them.

Completion Date: 12/19/2016

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

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

Observations

The facility failed to ensure that all of the annual evaluations for patients were signed by the medical director.

Patient #8's annual evaluation dated 02/16/2016 was signed by a narcotic treatment physician, but the physician was not the facility's medical director.

Patient #9's annual evaluation dated 08/12/2016 was signed by a narcotic treatment physician, but the physician was not the facility's medical director.

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

Plan of Correction

Program Director provided a training to the medical staff on 1/6/17 addressing the annual evaluations for patients to ensure the understanding of the need for the Medical Director to be the only person who has the authority to sign the annual evaluations for patients. The Clinical Supervisor will review signed annual evaluations monthly and report findings to Program Director.

Completion Date: 1/6/17.

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 that patients participated in the development of treatment plans in 3 of 8 records reviewed.

Patient #10 was admitted for treatment on 3/08/2016. The patient's treatment plan was signed by the counselor on 4/18/2016 but was not signed by the patient until 7/29/2016.

Patient #11 was admitted for treatment on 4/25/2016. The patient's treatment plan was signed by the counselor on 6/16/2016 but not signed by the patient.

Patient #13 was admitted for treatment on 7/26/2016. The patient's treatment plan was signed by the counselor on 8/22/2016 but not signed by the patient.

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

Plan of Correction

Program Director provided a training to clinical staff on 1/5/17 addressing individual treatment plans, the patient participation in the development in their individual treatment plans, and the required written documentation. The Clinical Supervisor will review for approval before acceptance and signing off on treatment plans. The Program Director will review for compliance quarterly.

Completion Date: 1/5/17

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

The facility failed to ensure that treatment plans were updated at least every 60 days in 4 of 9 patient records reviewed during the onsite inspection.

Patient #1 was admitted for treatment on 11/30/2015. The patient had a treatment plan update completed on 05/10/2016, but the next update was not completed until 07/29/2016.

Patient #4 was admitted for treatment on 01/27/2016. The patient had a treatment plan update completed on 07/13/2016, but the next update was not completed until 09/26/2016.

Patient #11 was admitted for treatment on 04/25/2016. The patient had a treatment plan update completed on 08/12/2016, but the next update was not completed until 10/29/2016.

Patient #13 was admitted for treatment on 07/26/2016. The patient had a treatment plan update completed on 09/23/2016, but the next update was not completed until 11/30/2016.

These findings were reviewed with facility staff as part of the

Plan of Correction

Program Director provided a training to clinical staff on 1/5/17 addressing individual treatment plans, the patient participation in the development in their individual treatment plans, and the treatment plans required time of at least every 60 days to be reviewed and updated. The Clinical Supervisor will review for approval before acceptance and signing off on treatment plans. The Program Director will review for compliance quarterly.

Completion Date: 1/5/17

inspection process.

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DISCOVERY HOUSE HA

99 SOUTH CAMERON STREET
HARRISBURG, PA 17101

Survey conducted on 11/25/2015

INITIAL COMMENTS

This report is a result of an on-site inspection conducted for the licensure renewal and the approval to use a narcotic agent, specifically methadone, in the treatment of narcotic addiction. This inspection was conducted on November 24 - 25, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House HA 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 (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 an observation during the physical plant inspection, the facility failed to ensure that the grounds of the facility were sanitary and in good repair.

The findings include:

A physical plant inspection was conducted on 11/25/2015. A Department licensing specialist observed multiple areas throughout the facility that were either unsanitary or in disrepair. The following deficiencies were found:

2' x1 ' section of the bottom of two ceiling tiles that were resting on the floor in the mechanical room were covered in mold.

lower level of the window next to the exit door that leads to the sidewalk on South Cameron Street had multiple holes and spider cracks that were sustained from gunfire.

metal latch faceplate on exit door that leads to the sidewalk on South Cameron Street was protruding from the door as it was only being held in place by one loose screw.

Plan of Correction

Facility Director has removed old ceiling tiles, lower level window has been replaced, and door has been repaired as of 12/11/15. Program Manager will complete a quarterly walk through of all areas of Discovery House on a quarterly basis to ensure the facility and grounds are in good repair. Program Director to review walk through inspection on a quarterly basis to ensure compliance. This was effective as of 12/11/15.

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

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Based on review of the patient records, the facility failed to ensure that a random urinalysis was completed at least monthly in one of twenty-one patient records reviewed.

The findings include:

Twenty-one patient records requiring monthly urinalysis drug screenings were reviewed on 11/24/2015 - 11/25/2015. The facility failed to ensure that urinalysis drug screenings were completed at least monthly in patient records # 3, 5 and 13.

Patient # 3 was admitted into the methadone clinic on 2/6/2015 and was still an active patient at the time of the inspection. A urinalysis drug screening was not completed in August 2015 for patient # 3.

Patient # 5 was admitted into the methadone clinic on 2/20/2015 and was still an active patient at the time of the inspection. A urinalysis drug screening was not completed in June 2015 for patient # 5.

Patient # 13 was admitted into the methadone clinic on 2/12/2014 and was still an active patient at the time of the inspection. A urinalysis drug screening was not completed in September 2015 for patient # 13.

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

Plan of Correction

Discovery House nursing staff were provided a training on required monthly random urinalysis on 12/29/15. Charge Nurse will run urinalysis reports to identify any patients that have not provided or are scheduled for a urinalysis and ensure all patients have minimally provided the required one random monthly urinalysis. This will take place during the last week of every month. Program Director and Clinical supervisors will monitor via chart reviews. This took effect on 12/29/15.

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

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

Observations

Plan of Correction

Based on a review facility policies and an observation of the dispensing unit, the narcotic treatment facility failed to ensure that only authorized personnel were permitted within the dispensing unit.

The findings include:

An inspection of dispensing unit was conducted on 11/25/2015 between 8:12 AM - 8:30 AM. At 8:19 AM, a Department licensing specialist observed a clinical supervisor enter the secured dispensing area, provide a brief verbal statement to nursing staff regarding a patient, and then exit the secured dispensing area. The facility's policy regarding authorized personnel that are permitted within the dispensing unit did not list a clinical supervisor as authorized personnel.

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

Program Director provided a training to staff on 12/29/2015 which reviewed dispensary access regulations. Program Director also updated the dispensary access form to correctly identify those allowed access. Program Director to monitor on ongoing basis to ensure compliance. This took effect on 12/29/2015

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CENTER FOR BEHAVIORAL HEALTH-PA, INC.

1914 MERCER AVENUE
FARRELL, PA 16121

Survey conducted on 11/08/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on November 7-8, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Center for Behavioral Health-HA, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.

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

Plan of Correction
The Recruitment and Hiring Policy will be updated by the Clinical Services Department,and Clinic Director will oversee this process. This policy will be updated by 1/15/2018. Every effort will be made to hire staff persons representative of the population served. Program Staff will continue to work with the Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project.

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers.

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

Plan of Correction
The Personnel Policy will be revised to include the utilization of volunteers in the project. Clinical Services Department will be responsible for updating the policy, and Clinic Director will oversee this process. Policy will be updated by 1/15/2018. Clinic Director will review the policy revision with all staff in the January All Staff Meeting.

709.30 (1) LICENSURE Client rights

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

Observations

The facility failed to document written policies and procedures regarding all of the client rights.

The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or

(6) Clients have the right to submit rebuttal data or memoranda to their own record.

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

Plan of Correction

The Clinical Services Department will update the Client Rights Policy and Procedure to include the client's right to appeal a decision limiting access to records to the director; clients having the right to request the correction of inaccurate, irrelevant, outdated, or incomplete information in their records; and clients having the right to submit rebuttal data or memoranda to their own record. Clinic Director will oversee this process, and will review the updated policy and procedure with all staff in the January All Staff Meeting.

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents:

709.34 (a)

(4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day.

(6) Event at the facility requiring the presence of police, fire or ambulance personnel.

(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.

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

Plan of Correction

The Clinical Services Department will revise the Unusual Incident Policy and Procedure to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood, or other occurrence which closes the facility for more than one day, including if the project requires the presence of police, fire, or ambulance personnel on site.

Policy and Procedure will also be revised by the Clinical Services Department to ensure that the reporting of an unusual incident to an entity is in full compliance with State Confidentiality laws.

Policy revisions will be completed by the Clinical Services Department by 1/15/2018. Clinic Director will review these policy and procedure revisions with all staff in the January 2018 All Staff Meeting.

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures.

The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4).

Plan of Correction

The Clinical Services Department will revise the Transfer Policy and Procedure to include that the project will transfer a patient within 7 days of the patient's request to be transferred. Clinic Director will review policy and procedure revisions with all staff in the January 2018 All Staff Meeting.

709.20(4) states that the receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program.

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

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).

The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives.

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

Plan of Correction

The Clinical Services Department will revise the Termination Policy and Procedure to include that a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program Management will review these policy and procedure revisions with all staff in the January 2018 All Staff Meeting.

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CENTER FOR BEHAVIORAL HEALTH-PA, INC.

1914 MERCER AVENUE
FARRELL, PA 16121

Survey conducted on 10/21/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on October 20-21, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Center for Behavioral Health - HA, Inc. 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

715.20(4) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (4) The receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program.

Observations

The facility failed to document that it notified the referring facility of the admission and initial dosing of the patient in 2 of 4 patient records.

Twelve patient records were reviewed on October 20 & 21, 2016. Four of the patients reviewed transferred to the facility from another narcotic treatment program.

Patient # 6 was admitted on April 7, 2016 and patient # 10 was admitted on December 21, 2015. Both patients were referred by another narcotic treatment program and there was no documentation of the transferring facility being notified of the admission and initial dosing of the patients.

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

Plan of Correction

The Clinic Director met with Program Manager on 10/24/16 to discuss the procedure for completing Transfer Acknowledgments on all incoming transfers. Program Manager completes intakes for all admissions. Program Manager will ensure that Transfer Acknowledgment forms are completed for every patient who transfers to our facility from another MMT. The Transfer Acknowledgments will be completed on the day of the transfer admission. The Transfer Acknowledgment will then be faxed to the transferring clinic. Program Manager will keep a copy of the fax transmittal sheet that shows the Transfer Acknowledgement was faxed successfully. Both the Transfer Acknowledgment Form and fax transmittal sheet will be scanned into the "Stored Images' section of the patient's EHR.

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CENTER FOR BEHAVIORAL HEALTH-PA, INC.

301 SMITH DRIVE, SUITE 3
CRANBERRY TOWNSHIP, PA 16066

Survey conducted on 11/17/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on November 16-17, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Center for Behavioral Health-PA, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
Recruitment and hiring policy will be revised by the Clinical Services Department to address the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project. Clinic Director will oversee.

705.24 (5) LICENSURE Bathrooms.

705.24. Bathrooms. The nonresidential facility shall: (5) Ventilate bathrooms by exhaust fan or window.

Observations
The facility failed to have a bathroom that was ventilated by an operable exhaust fan or window during the physical plant inspection on November 17, 2017. The client bathroom did not have an operable fan or window. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The condo association handy man has been contacted to replace the broken exhaust fan in the client bathroom. This repair will take place within the next week. Clinic Director will oversee.

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
Personnel policy will be revised by the Clinical Services Department to include the utilization of volunteers in the project. Program will review policy revision with all staff in the January all staff meeting. Clinic Director will oversee.

709.30 (1) LICENSURE Client rights

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

Observations

The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedure manual and the client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access to their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Client Rights policy and procedure will be revised by the Clinical Services Department to include the client's right to appeal a decision limiting access to records to the director; clients having the right to request the correction of inaccurate, irrelevant, outdated, or incomplete information in their records; and that clients have the right to submit rebuttal data or memoranda to their own record. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting. Clinic Director will oversee.

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Unusual Incident policy and procedure will be revised by the Clinical Services Department to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site. Policy and procedure will be revised by Clinical Services Department to ensure that the revised policy and procedure of reporting an unusual incident to an entity is in full compliance with State confidentiality laws. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting. Clinic Director to oversee.

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

The facility failed to verify the individual's emergency contact in seven of nine client records reviewed on November 16-17, 2017. Client records # 1, 2, 3, 5, 9, 10 and 11 did not document an emergency contact. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Program Specialist will conduct training to ensure all staff are offering patients the ability to place a consent to release on file for an emergency contact. All patients will be provided with opportunity to add an emergency contact consent to release in his.her chart. If patients refuse to allow an emergency contact on file this will be documented in the patient chart. Program Specialist will implement and Clinical Director will complete audits to oversee.

715.10(f) LICENSURE Pregnant patients

(f) The narcotic treatment program shall ensure that each female patient is fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.

Observations

The facility failed to fully inform each female patient of the possible risk, to her and her unborn child, of continued use of illicit drugs and from the use of, or withdrawal from a narcotic drug administered or dispensed by the program for comprehensive maintenance or detoxification treatment in three of four patient records reviewed on November 16-17, 2017. Client # 2 was admitted on February 7, 2017. Documentation that the client was fully informed of the possible risk to her and her unborn child occurred on

Plan of Correction

The medical staff have been trained to utilize the "Pregnant Patient Acknowledgement of Risks" form with each female patient. This document informs the female patient of the possible risk, to her and her unborn child, of continued use of illicit drugs and from the use of, or withdrawal from a narcotic drug administered or dispensed by the program for comprehensive maintenance or detoxification treatment. The Medical Director and CRNP will implement this form and the Clinic Director will oversee and perform chart audits to

September 1, 2017 when the client was confirmed pregnant. There was no documentation in client records # 10 and 11 that they were fully informed of the possible risk. These findings were reviewed with facility staff during the licensing process.

ensure form is being used and female patients are informed of the risks.

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient, and 715.20(4). 709.20(4) states that the receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

Transfer policy and procedure will be revised by the Clinical Services Department to include the project will transfer a patient within 7 days of the patients request to be transferred. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting. Clinic Director will oversee.

Transfer policy and procedure will be revised by the Clinical Services Department to include the project shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic program. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting. Program Specialist will oversee.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedure manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Termination policy and procedure will be revised by the Clinical Services Department to include a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting. Clinic Director will oversee.

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CENTER FOR BEHAVIORAL HEALTH-PA, INC.

301 SMITH DRIVE, SUITE 3
CRANBERRY TOWNSHIP, PA 16066

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/18/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on October 17-18, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Center for Behavioral Health-PA, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.7(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

The facility failed to document that each counselor met the qualifications for the position of counselor.

The personnel and training records were reviewed on October 17, 2016. Employee #7 was found to not meet the qualifications for the position of counselor.

Employee #7 was hired as a counselor on 9/7/16. Employee

Plan of Correction

Employee #7 has been moved to a counselor assistant as of 10/27/2016. Direct observation and increased supervision has begun. Employee #7 has been provided with the CADC application and will begin the process to become certified. Employee #7 training plan has been updated to reflect her new training needs.

Clinical Supervisor will provide the direct observation and supervision. Clinical Supervisor will assist employee #7 through the CADC application and testing.

#7 holds a Bachelor of Arts degree in Italian, which does not meet the qualifications for the position of counselor.

Moving forward, Clinical Supervisor and Clinic Director will ensure the counselor candidate will meet the educational and experience identified in regulations prior to hire.

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

Clinic director will oversee.

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 25 clock hours of training for each counselor for the 2015 training year.

The personnel and training records were reviewed on October 17, 2016. The 2015 training year was reviewed, which covers January through December. Employee #4 did not have at least 25 clock hours documented for the 2015 training year.

Employee #4 was hired as a counselor on 11/12/13. Employee #4 completed 20.25 hours of training for the 2015 training year.

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

Plan of Correction

To ensure that all staff obtain the minimum required training, supervisors will monitor training attendance monthly. At this time, all staff are scheduled to attend training to meet his/her minimum training requirements for the current year.

Clinical Supervisor will maintain the training offered and suggest training according to individual needs. Clinical Supervisor will ensure that training needs are met for each staff.

Clinic Director will oversee.

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DISCOVERY HOUSE CU - INC.
214 AIRPORT ROAD
CLEARFIELD, PA 16830

Survey conducted on 12/13/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on December 12-13, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House CU-Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
Clinical Services Department will revise the recruitment and hiring policy to address the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort will be made to hire staff persons representative of the population served. Program staff will continue to work with Human Resources Business Partner in the recruitment and hiring of appropriate staff for the project.

Completion Date:

1/15/2018

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
Clinical Services Department will revise the Personnel policy to include the utilization of volunteers in the project. Program will review policy revision with all staff in the January all staff meeting.

Completion Date:

1/15/2018

709.30 (1) LICENSURE Client rights

§ 709.30. Client rights. The project shall develop written policies and procedures on client rights and document written acknowledgement by clients that they have been notified of those rights. (1) A client receiving care or treatment under

section 7 of the act (71 P. S. § 1690.107) shall retain civil rights and liberties except as provided by statute. No client may be deprived of a civil right solely by reason of treatment.

Observations

The facility failed to document written policies and procedures regarding all of the client rights. The policy and procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

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

Completion Date:

1/15/2018

709.32 (b) LICENSURE Medication control

§ 709.32. Medication control. (b) Verbal orders for medication can be given only by a physician or other medical professional authorized by State and Federal law to prescribe medication and verbal orders may be received only by another physician or medical professional authorized by State and Federal law to receive verbal orders. When a verbal or telephone order is given, it has to be authenticated in writing by a physician or other medical professional authorized by State and Federal law to prescribe medication. In detoxification levels of care, written authentication shall occur no later than 24 hours from the time the order was given. Otherwise, written authentication shall occur within 3 business days from the time the order was given.

Observations

The facility failed to have the physician sign a verbal order within three business days of the when the order was given for records reviewed on December 12-13, 2017. Record # 1 - A Verbal Order was given on December 6, 2017. There was no documentation that the order had been signed by a physcian. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A training was held on 12/14/17 with the medical staff explaining the importance of making sure verbal orders are signed off by the medical director within 24 hours. The nurse manager will review all orders daily to make sure they are signed off in the allotted time frame. The Program Director will do sporadic checks to make sure the verbal orders are signed.

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Clinical Services Department will revise the Unusual Incident policy and procedure to include how the project will report and respond to a significant disruption of services due to a disaster such as fire, storm, flood or other occurrence which closes the facility for more than one day including if the project requires the presence of police, fire, or ambulance personnel on site. Policy and procedure will be revised to ensure that the revised policy and procedure of reporting an unusual incident to an entity is in full compliance with State confidentiality laws. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

Completion Date:

1/15/2018

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

Plan of Correction

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). These findings were reviewed with facility staff during the licensing process.

715.20(4)

Clinical Services Department will revise the Transfer policy and procedure to include the project will transfer a patient within 7 days of the patients request to be transferred. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

709.20(4)

Clinical Services Department will revise the Transfer policy and procedure to include the project shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic program. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

715.21(1)(i-iv)

Clinical Services Department will revise the Termination policy and procedure to include a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program management will review policy and procedure revisions with all staff at the January 2018 staff meeting.

Completion Date:

1/15/2018

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DISCOVERY HOUSE CU - INC.
214 AIRPORT ROAD
CLEARFIELD, PA 16830

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Survey conducted on 12/01/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on December 1, 2016 by staff from the Division of Accountability and Program Improvement. Based on the findings of the investigation, Discovery House CU-Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

705.27 (1) LICENSURE General safety and emergency procedures.
705.27. General safety and emergency procedures. The nonresidential facility shall: (1) Be free of rodent and insect infestation.

Observations

A physical plant inspection was conducted on December 1, 2016. Based on this inspection, the facility failed to ensure that it was free of rodent infestation as there were mice excrements under the sink and bait traps in the staff kitchen.

In addition, monthly exterminator invoices were reviewed that indicated bait traps were set and were being monitored.

Plan of Correction

The Program Director and Program Manager met regarding the rodent infestation 12/1/16 and effective immediately the Program Manager will do bi-weekly facility inspections to ensure that the rodents are being taken care of. We will continue to have the exterminator come on a monthly basis and when we see an increase in infestation we will have them called in on a weekly basis or until it is taken care of.

We will continue with the bait traps.

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DISCOVERY HOUSE CU - INC.

214 AIRPORT ROAD
CLEARFIELD, PA 16830

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Survey conducted on 04/26/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on April 26, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, Discovery House CU-Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

705.9 (1) LICENSURE General safety and emergency procedures.

705.9. General safety and emergency procedures. The residential facility shall: (1) Be free of rodent and insect infestation.

Observations

A physical plant inspection was conducted on April 26, 2017. Based on this inspection, the facility failed to be free from rodent infestation.

During the physical plant walk through mouse excrement was observed under the kitchen sink in the staff kitchen and in a closet off the hallway.

Plan of Correction

On May 5, 2017, Orkin Pest Control was notified to do an internal and external inspection of the facility. After the inspection, an agreement was signed. On May 10,2017 Orkin did their first on site visit to free our facility from rodents.

Luzier Cleaning Services was notified to re-clean and sanitize the facility effective immediately. The Program Director will be incontact with each vendor to get updates on the progress and will inspect the facility on a weekly basis.

715.6(a)(2) LICENSURE Physician staffing

(a) A narcotic treatment program shall designate a medical director to assume responsibility for administering all medical services performed by the narcotic treatment program. (2) When a narcotic treatment program is unable to hire a medical director who meets the qualifications in paragraph (1), the narcotic treatment program may hire an interim medical director. The narcotic treatment program shall develop and submit to the Department for approval a training plan for the interim medical director, addressing the measures to be taken for the interim medical director to achieve minimal competencies and proficiencies until the interim medical director meets qualifications identified in paragraph (1)(i), (ii) or (iii). The interim medical director shall meet the qualifications within 36 months of being hired.

Observations

A review of employee personnel records was conducted on April 26, 2017. Based on this review, the facility failed submit to the Department, for approval, a training plan for the interim medical director.

A review of the interim medical director's personnel file revealed that he did not have three years documented experience in the provision of services to persons who are addicted to alcohol or other drugs.

Plan of Correction

Prior to hiring a medical director the Program Director will review the state regulations pertaining to the qualifications of an interim medical director to ensure he/she meets the qualifications. If the interim medical director does not meet the requirements, the narcotic treatment program shall develop and submit to the D.O.H for approval a training plan addressing measures that will be taken for the interim medical director to achieve the qualifications within the specified time frame. The Program Director will monitor to ensure the interim director meets the qualifications within the specified time frame. A revised training plan for Dr Hall was submitted to the D.O.H on 05/17/2017 for approval.

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DISCOVERY HOUSE CU - INC.
214 AIRPORT ROAD
CLEARFIELD, PA 16830

Survey conducted on 12/21/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection, and a methadone monitoring inspection conducted on December 21-22, 2016, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Discovery House CU - Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

705.28 (d) (5) LICENSURE Fire safety.
705.28. Fire safety. (d) Fire drills. The nonresidential facility shall: (5) Prepare alternate exit routes to be used during fire drills.

Observations
The facility has a total of 3 exits. The facility used all 3 exits for all fire drills conducted from 12/17/2015 through 11/29/2016.

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

Plan of Correction
The Program Director an Program Manager had a meeting and effective December 26,2016 Discovery House shall prepare alternate exit routes to be used during fire drills. The facility currently used all 3 exits for all fire drills. The program manager will monitor compliance and the facility director will do sporadic checks to ensure compliance.

715.12(1-5) LICENSURE Informed patient consent
A narcotic treatment program shall obtain an informed, voluntary, written consent before an agent may be administered to the patient for either maintenance or detoxification treatment. The following shall appear on the patient consent form: (1) That methadone and LAAM are narcotic drugs which can be harmful if taken without medical supervision. (2) That methadone and LAAM are addictive medications and may, like other drugs used in medical practices, produce adverse results. (3) That alternative methods of treatment exist. (4) That the possible risks and complications of treatment have been explained to the patient. (5) That methadone is transmitted to the unborn child and will cause physical dependence.

Observations
The facility failed to obtain informed voluntary consents containing all of the necessary information in 2 patient records.

Patient #11, a female patient, was admitted for narcotic treatment on 11/03/2016, but the facility did not obtain a voluntary consent form signed by the patient that included information that methadone is transmitted to unborn children.

Patient #12, a female patient, was admitted for narcotic treatment on 09/27/2016, but the facility did not obtain a voluntary consent form signed by the patient that included information that methadone is transmitted to unborn children.

Plan of Correction
The Program Director will work with Acadia and the Regional Director to revisit the use of the old consent to treat form which contained information for pregnant females than methadone is transmitted to the unborn child. Effective immediately the Program Director will set up meetings with Acadia to get the voluntary consent form for pregnant females included in the forms section of the chart. The Program Director will work with the Regional Director to ensure this is in compliance by 1/31/2017.

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

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

The facility failed to document a random urinalysis at least monthly in one patient record.

Patient #10 was admitted on August 19, 2015 and discharged on 10-17-2016. There was no documentation of a complete urinalysis for the month of April 2016.

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

Plan of Correction

The Program Director held meeting on 12/23/16 with the medical staff explaining the importance of making sure that all patients have a random monthly drug screen. Effective 12/30/2016 each Discovery House patient will have a random monthly drug screen. This will be monitored through the monthly drug screen reports. The Nurse manager will run the reports to ensure compliance. The Program Director will do sporadic checks to ensure compliance.

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

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

Observations

The facility failed to ensure that all medication orders were properly documented in 1of 10 patient records reviewed.

Patient #12 was given a 13 day supply of take-home methadone from 12/18/2016, through 12/30/ 2016, but the order for the take-home methadone was not signed by a physician.

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

Plan of Correction

The Program Director held meeting on 12/23/16 with the medical staff explaining the importance of making sure that all medical orders are signed by the medical director. Effective immediately,12/23/2016 the physician will sign the order then will reopen the order and make sure that his signature is present. The nurse manager will monitor compliance and the Program Director will do sporadic check to ensure compliance.

715.20(1) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (1) The transferring narcotic treatment program shall transfer patient files which include admission date, medical and psychosocial summaries, dosage level, urinalysis reports or summary, exception requests, and current status of the patient, and shall contain the written consent of the patient.

Observations

The facilty failed to transfer the required patient files in one of two patient record which were reviewed on December 20-21, 2016.

Plan of Correction

The Program Director and Clinical Supervisor held a meeting on 12/23/16 explaining the importance of sending the transferring documents of the required patient to the receiving facility and keeping the transmittal paper. Effective

Patient # 8 was discharged as a transfer to another narcotic treatment facility on November 28, 2016. There was no documentation of the required patient files being transferred to the receiving facility.

immediately all patient that are transferred out will have their transferring documents placed in their charts along with the transmittal paper. The Clinical Supervisor will monitor compliance when doing the discharge audit and document that it has been sent. The Program Manager will do sporadic checks to ensure compliance.

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

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DISCOVERY HOUSE
3438 ROUTE 764
DUNCANSVILLE, PA 16635

Survey conducted on 01/27/2016

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on January 26-27, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House - Duncansville 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

Based on a review of patient records, the facility failed to notify the patient, in writing, of a decision to involuntarily terminate the patient's treatment at the project, in one of one patient records.The findings include:Eleven patient records were reviewed on January 26-27, 2016. Four of the patient records reviewed were discharged patients. One of the discharged patients was involuntarily terminated from treatment at the project. The facility failed to notify the patient, in writing, of a decision to involuntarily terminate the patient's treatment at the project, in patient record # 6.Patient #6 was admitted into treatment on January 28, 2015 and was involuntarily terminated from the project on September 15, 2015. There was no documentation of written notification provided to the patient as of the on-site inspection which was conducted on January 26-27, 2016.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

709.33(a) LICENSURE

Notification of Termination

A meeting was held on 02/04/2106 for all staff to review the policy of administrative withdrawals. We reviewed the steps that need to be followed and the form that needs to be completed. Every patient that is given an involuntary discharge will be given written documentation of the discharge. The clinic director will be responsible for ensuring that the proper procedure is followed when a patient is administratively discharged.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Based on review of the patient records, the facility failed to obtain a complete drug screen urinalysis prior to the administration of buprenorphine, a narcotic agent, and at least monthly thereafter. A complete drug screen includes receiving the results from the CLIA and Department of Health approved laboratory. The findings include:Four buprenorphine patient records were reviewed on January 26 - 27, 2016. All patients are required to complete a drug screen urinalysis prior to the administration of

Plan of Correction

715.14(a) LICENSURE

Urine testing:

On 01/28/2016 we began to send all urine analysis screens out to a laboratory for testing. We are currently utilizing clinical science for this. A patient will not receive medication

buprenorphine, a narcotic agent, and at least monthly thereafter. A complete urine drug screen includes receiving the results from the CLIA and Department of Health approved laboratory. The facility failed to obtain a complete drug screen urinalysis prior to the administration of buprenorphine, a narcotic agent, and monthly thereafter in records # 3, 4, 5 and 6.Patient #3 was admitted on April 29, 2015. Patient #3 received their first dose of buprenorphine on May 5, 2015. The initial and monthly urine screens have been completed by the facility; however, none of the urine samples, including the initial were sent out to a laboratory for urinalysis.Patient #4 was admitted on June 25, 2015. Patient #4 received their first dose of buprenorphine on July 7, 2015. The initial and monthly urine screens have been completed by the facility; however, none of the urine samples, including the initial were sent out to a laboratory for urinalysis.Patient #5 was admitted on February 4, 2015. Patient #5 received their first dose of buprenorphine on February 10, 2015. The initial and monthly urine screens have been completed by the facility; however, none of the urine samples, including the initial were sent out to a laboratory for urinalysis.Patient #6 was admitted on January 28, 2015. Patient #6 received their first dose of buprenorphine on February 3, 2015. The initial and monthly urine screens have been completed by the facility; however, none of the urine samples, including the initial were sent out to a laboratory for urinalysis.These findings were reviewed with facility staff during the licensing process.

prior to the results of the urinalysis screen coming back from the lab. The LPN in our program will be responsible for ensuring that all urine analysis screens are sent out for testing.

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

Based on a review of patient records, the facility's physician failed to adhere to the dosing protocol listed on the medication by ordering that single dose Suboxone film be halved and/or quartered in two of four patient records. The medication packaging identifies this as a single dose medication.The findings include:On September 1, 2015, the physician prescribed Suboxone 8 mg/2 mg SL film, 1/2 film QAM (morning) and 1/4 film QPM (evening) daily for patient #5.On February 3, February 12, February 19, February 26, March 12, June 12, June 25, July 23, August 6, August 20, August 27, and September 10, 2015, the physician prescribed Suboxone 8 mg/2 mg SL film, 1/2 film BID (twice daily). On March 26, April 2, April 16, April 30, May 14 and May 28, 2015, the physician prescribed Suboxone 8mg/2 mg SL film, 1/2 film tid (three times daily) for patient #6.Suboxone film is not formulated to be cut into smaller doses. Prescriptions need to be for the manufactured quantities of 12 mg/3 mg, 8 mg/2 mg, 4 mg/1 mg or 2 mg/.5 mg doses. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

715.15(b) LICENSURE

Medication dosage

I will hold a meeting with the prescribing physician on 2/9/2016. We will review the prescribing of medication the way that it is intended. We will ensure that he only prescribes Suboxone film in the manufactured quantities of 12 mg/3 mg, 8 mg/2 mg, 4 mg/1 mg or 2 mg/.5 mg doses. The prescribing physician will be responsible for monitoring this.

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DISCOVERY HOUSE

3438 ROUTE 764
DUNCANSVILLE, PA 16635

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Survey conducted on 01/25/2018

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on January 23-25, 2018 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.3 (b) LICENSURE Recruitment and Hiring

704.3. General requirements for projects. (b) The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative of that population.

Observations
The facility failed to document a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served and that every effort will be made to hire staff persons representative of that population.These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction
The Recruitment and Hiring Policy will be updated by the Clinical Services Department, and Clinic Director will oversee this process. The policy will be updated by 1/15/2018. Every effort will be made to hire staff persons representative of the population served. Program Staff will continue to work with the Human Resource Business Partner in the recruitment and hiring of appropriate staff for the project.

709.26 (a) (1) LICENSURE Personnel management.

§ 709.26. Personnel management. (a) The governing body shall adopt and have implemented written project personnel policies and procedures in compliance with State and Federal employment laws. In addition, the written policies and procedures must specifically include, but are not limited to: (1) Utilization of volunteers.

Observations
The facility failed to have written project policies and procedures regarding the utilization of volunteers. These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Personal Policy will be revised to include the utilization of volunteers in the project. Clinical Services Department will be responsible for updating the policy, and the Clinic Director will oversee this process. Policy will be updated by 1/15/2018. Clinic Director will review the policy revision with all staff in the February Staff Meeting.

709.30 (1) LICENSURE Client rights

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

Observations
The facility failed to document written policies and procedures regarding all of the client rights. The policy and

Plan of Correction
The Clinical Services Department will update the Client Rights Policy and Procedure to include the client's right to

procedures manual and client handbook were reviewed. Neither the policy manual nor the client handbook documented 709.30 (4) Clients have the right to appeal a decision limiting access the their records to the director, (5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records, or(6) Clients have the right to submit rebuttal data or memoranda to their own record. These findings were reviewed with facility staff during the licensing process.

appeal a decision limiting access to records to the director; clients having the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records; and clients having the right to submit rebuttal data or memoranda to their own record. Clinic Director will oversee this process, and will review the updated policy and procedure with all staff in the February Staff Meeting.

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 notify the client, in writing, of a decision to involuntarily terminate the client's treatment at the project.Client #6 was admitted to treatment on 4/7/17 and involuntarily terminated from treatment on 7/20/17. There was not documentation that client #6 was provided with a written notification of involuntary termination.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A meeting will be held on 2/21/2018 for all staff to review the policy of administrative withdrawals. The steps that need to be followed and the forms that need to be completed will be reviewed. Every patient that is given an involuntary discharge will be given written documentation of the discharge. The Clinic Director and Clinical Supervisor will be responsible for insuring that the proper procedure is followed when a patient receives an administrative withdrawal

709.34 (a) (1) LICENSURE Reporting of unusual incidents

§ 709.34. Reporting of unusual incidents. (a) The project shall develop and implement policies and procedures to respond to the following unusual incidents: (1) Physical assault or sexual assault by staff or a client.

Observations

The facility failed to develop and policies and procedures to respond to the following unusual incidents: 709.34 (a) (4) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence which closes the facility for more than 1 day. (6) Event at the facility requiring the presence of police, fire or ambulance personnel.(b) (5) Reporting mechanism to ensure that reporting of an unusual incident to an entity is in compliance with State confidentiality laws.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Services Department will revise the Unusual Incident Policy and Procedure to include how the project will report and respond to a significant disruption of services due to disaster such as fire, storm, flood, or other occurrence which closes the facility for more than one day, including if the project requires the presence of police, fire, or ambulance personal on site.

Policy and Procedure will also be revised by the Clinical Services Department to ensure that the reporting of an unusual incident to an entity is in full compliance with State Confidentiality laws.

Policy revisions will be completed by the Clinical Services Department by 1/15/2018. Clinic Director will review these policy and procedure with all staff at the February 2018 Staff Meeting.

715.6(d) LICENSURE Physician Staffing

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

Observations

The facility failed to document at least 1 hour of physician hours per week onsite for every ten patients.The physician and physician assistant hours were reviewed on January 23-25, 2018. The physician assistant was not employed at the facilty for the period of October 1, 2017 to October 22, 2017. The physican hours and census for those weeks were as follows:October 1-7, 2017 - 15 physician hours, 383 patients (38.3 physician hours required) October 8-14, 2017 - 15 physician hours, 385 patients (38.5 physician hours required) October 15-21, 2017 - 15 physician hours, 387 patients (38.7 physician hours required) These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The DH physician will provide the required on-site hours. The physician is responsible for providing 1/3 of the required hours and the Physician Assistant is responsible for providing the remaining 2/3 of the required hours. A meeting will be held on 2/20/2018 with the Medical Director to review the policy on physician staffing. The Clinic Director is responsible for monitoring and approving the hours spent on-site by the physician and physician assistant, this will be implemented immediately and monitored on an on-going basis.

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

The facility failed to document the initial face to face determination of current physiological dependence and a 1 year history of dependence at the time of intake.Buprenorphine patient records were reviewed on January 23-25, 2018. In patient record #13, the initial face to face assessment by the physician was reported to have occurred on 3/28/17; however, it was not signed by the physican until 10/27/17. In patient record #14, the initial face to face assessment by the physician was reported to have occurred on 10/3/17; however, it was not signed by the physican until 11/21/17.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A meeting will be held on 2/20/2018 with the Medical Director to review the policy on determining eligibility for admission into a narcotic treatment program. The DH physician shall document in the patient record the basis for the determination of current dependency and evidence of a 1 year history of addiction. The DH physician will sign the initial face to face assessment at the time of the patient visit. The Clinic Director will be responsible for monitoring the patient record to verify it was signed in a timely manner

715.10(f) LICENSURE Pregnant patients

(f) The narcotic treatment program shall ensure that each female patient is fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.

Observations

The facility failed to ensure that each female patient was fully informed of the possible risk to her or her unborn child from continued use of illicit drugs and from use of, or withdrawal from a narcotic drug administered or dispensed by the program in comprehensive maintenance or detoxification treatment.Buprenorphine and methadone patient records were reviewed on January 23-25, 2018. Patient # 1, 4, 5, 7 and 13 were identified as female patients. No notification regarding the risks (as noted above) were provided to these patients.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

During the intake process for both methadone and buprenorphine the DH Intake staff will inform the female patients of the possible risks to her or her unborn child of illicit drugs and from use of or withdrawal from a narcotic drug administered or dispensed by the program. The DH intake counselor will have the patient sign the following form Pregnant Patient Acknowledgment of Risks a copy of which will be given to the patient. The Clinical Supervisor will be responsible for insuring that the proper procedure is followed when a female patient enters the program. Implementation will begin immediately and reviewed on an on-going basis

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

The facility physician determined the patient dosage level, but failed to document it at the time of the determination. The documentation is completed by the physician via the " Weekly medical follow up " notes. Patient record #13 was reviewed on January 25, 2018. Patient #13 was admitted on 3/13/17. Eight " Weekly medical follow up " notes were signed six-seven months after the service occurred. " Weekly medical follow up " appointments occurred with the physician on 4/4/17 & 4/18/17, but not signed by the physician until 10/27/17. " Weekly medical follow up " appointment occurred with the physician on 5/16/17, but not signed by the physician until 11/21/17. " Weekly medical follow up " appointments occurred with the physician on 5/23/17, 5/30/17, 6/6/17, 6/20/17 and 6/30/17 but not signed by the physician until 12/22/17.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A meeting will be held on 2/20/2018 with the Medical Director to review the policy on determining the proper dosage level for a patient. The DH physician will complete all dose reviews, the physician has been advised to sign dose reviews on the date of completion. The Clinic Director will monitor patient dose reviews on a daily basis to assure timely signing of patient records. Implementation will begin immediately and reviewed on an on-going basis

715.16(c)(2)(i-iv) LICENSURE Take-home previliges

(c) A narcotic treatment program shall require a patient to come to the narcotic treatment program for observation daily or at least 6 days a week for comprehensive maintenance treatment, unless a patient is permitted to receive take-home medication as follows: (2) A narcotic treatment program may permit a patient to reduce attendance at the narcotic treatment program for observation to two times weekly and receive no more than a 3-day take-home supply of medication when in the reasonable clinical judgment of the narcotic treatment physician, which is documented in the patient record: (i) A patient demonstrates satisfactory adherence to narcotic treatment program rules for at least 2 years. (ii) A patient demonstrates substantial progress in rehabilitation. (iii) A patient demonstrates responsibility in handling narcotic drugs. (iv) A patient demonstrates that rehabilitation progress would improve by decreasing the frequency of attendance for observation.

Observations

The facility failed to document that the patient met the criteria for 5 days of take home medication in patient record #2.Methadone patient records were reviewed on January 23-25, 2018. Patient #2 was admitted as a transfer in on 10/6/17. On 10/27/17 an order was written that stated the patient was granted weekend privledges; however, due to an error, Monday through Friday take homes were checked. The patient was given 5 take home bottles for the weeks of 11/5/17 and 11/12/17 until the error was caught and changed back to weekend privledges.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A meeting was held on 2/19/2018 with the Clinical staff to review the regulations on take home privileges that all needed information is obtained and reviewed in the 8 point form prior to clinic action on take homes. The paperwork will contain information showing patient's satisfactory adherence to all applicable narcotic treatment program rules. The Clinical Supervisor will follow up to make sure the correct documentation is in the patient's chart prior to granting take homes. The Clinical Supervisor is responsible for training clinical staff and assuring accuracy of the 8 point form. The physician is responsible for reviewing and signing the 8 point and orders granting take homes. Implementation will begin immediately and reviewed on an on-going basis

715.20 LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient.

Observations

The facility failed to develop complete written transfer policies and procedures. The policy and procedure manual was reviewed. The policies and procedures did not include that the facility would transfer the patient within 7 days of the request of the patient and 715.20(4). 709.20(4) states that the receiving narcotic treatment program shall document in writing that it notified the transferring narcotic treatment program of the admission of the patient and the date of the initial dose given to the patient by the receiving narcotic treatment program. These findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

The Clinical Services Department will revise the Transfer Policy and Procedure to include that the project will transfer a patient within 7 days of the patent's request to be transferred. Clinic Director will review the policy and procedure revisions with all staff at the February 2018 Staff Meeting

715.20(1) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (1) The transferring narcotic treatment program shall transfer patient files which include admission date, medical and psychosocial summaries, dosage level, urinalysis reports or summary, exception requests, and current status of the patient, and shall contain the written consent of the patient.

Observations

The facilty failed to document that it transferred patient files for those patients that transferred to another narcotic treatment facility.Patient records were reviewed on January 23-25, 2018. Two of the patients reviewed transferred to another narcotic treatment facility. Patient record #7 did not include documentation that the required patient information was transferred to the new narcotic treatment facility.Patient #7 was admitted on 5/2/17 and transferred to another narcotic treatment facility on 8/2/17. There was no documentation in patient record #7 that patient information was transferred to the new narcotic treatment program, despite having a signed release of information in place.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Clinical staff training will be provided on procedures for transfer of patients to other narcotic treatment facilities. This will include training on documentation of information released. Training will be performed by the clinical supervisor. The Clinical Supervisor is responsible compliance with the standard. Implementation will begin immediately and reviewed on an on-going basis

715.21(1)(i-iv) LICENSURE Patient termination

A narcotic treatment program shall develop and implement policies and procedures regarding involuntary terminations. Involuntary terminations shall be initiated only when all other efforts to retain the patient in the program have failed. (1) A narcotic treatment program may involuntarily terminate a patient from the narcotic treatment program if it deems that the termination would be in the best interests of the health or safety of the patient and others, or the program finds any of the following conditions to exist: (i) The patient has committed or threatened to commit acts of physical violence in or around the narcotic treatment program premises. (ii) The patient possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the narcotic treatment program premises. (iii) The patient has been absent from the narcotic treatment program for 3 consecutive days or longer without cause. (iv) The patient has failed to follow treatment plan objectives.

Observations

The facility failed to develop policies which included 715.21 (1) (iv).The policy and procedures manual was reviewed. The policy did not include that a patient may be involuntarily discharged if the patient has failed to follow treatment plan objectives. These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Services Department will revise the Termination Policy and procedure to include that a patient may be involuntarily discharged from the project if the patient has failed to follow treatment plan objectives. Program Management will review these policy and procedure revisions with all staff at the February 2018 Staff Meeting.

715.23(b)(5) LICENSURE Patient records

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

Observations

The facility failed to document annual physicals in two of three patient records reviewed on January 23-25, 2018. Patient #8 was admitted on 10/9/15. There was no annual physical and reevaluation documented for 2017 for patient #8.Patient #10 was admitted on 11/1/03. There was no annual physical and reevaluation documented for 2017 for patient #10.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

A meeting will be held on 2/20/2018 with the Medical Director to review the policy on patient records/annual physicals. The DH physician or PA is responsible for completing the patient's annual physical, the DH Physician will complete the annual physical exam including the full documentation of a re-evaluation on the patient on a timely basis. The Clinic Director is responsible for compliance with the standard. Implementation will begin immediately and reviewed on an on-going basis

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DISCOVERY HOUSE
3438 ROUTE 764
DUNCANSVILLE, PA 16635

Survey conducted on 02/07/2017

INITIAL COMMENTS

This report is a result of an onsite licensure renewal and methadone monitoring inspection. The inspection was conducted on February 6-7, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the onsite inspection, Discovery House was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during the inspection:

Plan of Correction

704.11(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 at least 25 hour of training annually.

The onsite inspection was conducted on February 6-7, 2017. The training year reviewed was January - December 2016. Staff #4 did not document the completion of at least 25 hours of training for the 2016 training year.

Staff #4 was hired as a counselor on 7/1/15. Staff #4 had 9 hours of training documented for the 2016 training year.

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

Plan of Correction

All counselors will obtain at least 25 hours of training annually. Training assessments will be done annually. Trainings will be scheduled from this annual assessment and documented in the training binder once completed, which the Clinical Supervisor will maintain. Clinical Supervisor will monitor progress on a monthly basis and assign trainings to counselors when necessary. This will be immediate and ongoing. Clinical Supervisor will be responsible for full compliance with this POC.

705.24 (1) LICENSURE Bathrooms.

705.24. Bathrooms. The nonresidential facility shall: (1) Provide bathrooms to accommodate staff, clients and other users of the facility.

Observations

The facility failed to ventilate all bathrooms with an exhaust

Plan of Correction

The exhaust fan in the rear bathroom will be replaced by

fan or window.

The physical plant inspection was conducted on February 7, 2017 at which time the exhaust fan in one of the rear bathrooms was found to be inoperable. There was no window in the bathroom.

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

April 1, 2017. The Clinic Director will monitor for physical-plant compliance on a quarterly basis utilizing the Health and Safety check-list. Clinic Director will be responsible for full compliance.

705.26 (1) LICENSURE Heating and cooling.

705.26. Heating and cooling. The nonresidential facility: (1) Shall have a heating and cooling ventilation system that is adequate to maintain an indoor temperature of at least 65F in the winter. When indoor temperatures exceed 90F, mechanical ventilation such as fans or air conditioning shall be used.

Observations

The facility failed to prohibit the use of heaters that are not permanently mounted or installed.

The physical plant inspection was conducted on February 7, 2017 at which time a portable heater was found on the floor of one of the counseling offices.

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

Plan of Correction

All heaters that are not permanently mounted or installed will be removed from all office spaces immediately. This issue will be addressed during team meetings on a quarterly basis in order to remain in compliance and ensure this deficiency does not recur. This will be immediate and ongoing. Clinic Director will be responsible for full compliance with this POC.

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