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POCONO MOUNTAIN RECOVERY CENTER, LLC

3437 ROUTE 715
HENRYVILLE, PA 18332

Survey conducted on 04/28/2016

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on April 28, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the complaint investigation, the allegations against Pocono Mountain Recovery Center, LLC 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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POCONO MOUNTAIN RECOVERY CENTER, LLC

3437 ROUTE 715
HENRYVILLE, PA 18332

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/23/2016

INITIAL COMMENTS

This report is a result of a complaint investigation conducted by telephone and other correspondences from November 2, 2016 through November 23, 2016, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the complaint investigation, the allegations against Pocono Mountain Recovery Center, LLC were unsubstantiated. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

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POCONO MOUNTAIN RECOVERY CENTER, LLC

3437 ROUTE 715
HENRYVILLE, PA 18332

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 12/16/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and buprenorphine monitoring inspection conducted on December 15-16, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Pocono Mountain Recovery Center, LLC. was found to be not in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

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

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

Observations

Based on a review of the facility's Staffing Requirements Facility Summary Report and employee records, the facility failed to ensure that employees, #10 and #11 received the required trainings.

The TB/STD training was due to be completed by 8/27/2016 but was not documented as completed as of the date of the licensing inspection for employee #10.

The TB/STD training was due to be completed by 10/17/2016 but was not documented as completed as of the date of the licensing inspection for employee #11.

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

Plan of Correction

Employees #10 and #11 in fact did not attend the required training's within their first 2 years of hiring. These include TB/STD for both. These training's have been scheduled and employee #10 and #11 will attend TB/STD on 1/31/17. The Clinical Director and Human Resource Director will assume the role of auditing employee's training manuals. These manuals will be audited once every 2 months. Therefore, training manuals will have been inspected 6 times annually. This will ensure that all employees have attended not only the necessary training's but also training's required for new employees.

705.6 (3) LICENSURE Bathrooms.

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

Observations

The facility failed to ensure hot water temperatures did not exceed 120 degrees in all bathrooms.

Plan of Correction

The Executive Director and Clinical Director met with maintenance supervisor regarding the hot water situation. A

A physical plant inspection was conducted on December 16, 2016. The water temperatures in the follow rooms exceeded 120 degrees:

Restroom located in the nursing station sick-bay water temperature was 131.2 #11 bathroom water temperature was 136.5

Room #14 bathroom water temperature was 143.3 #20 bathroom water temperature was 143 #21 bathroom water temperature was 144.1 #23 bathroom water temperature was 140 #26 bathroom water temperature was 130 #1 on the female wing bathroom water temperature was 129.2 #2 on the female wing bathroom water temperature was 130.3 #4 on the female wing bathroom water temperature was 129.2 information was reviewed with facility staff during the licensing process.

licensed HVAC contractor was hired to repair the hot water that is inclusive of installing hot water holding tanks between rooms. These holding tanks will monitor the hot water by either decreasing or increasing the temperature before entering the rooms. Until this is accomplished, maintenance supervisor will monitor hot water in all rooms especially rooms 11, 14, 21, 26, 29 to ensure the proper 120 degree temperature is maintained. Maintenance supervisor will report his finding 2 times weekly to the Executive Director of Clinical Director.

709.28 (c) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record.

Observations

Based on a review of client records conducted on December 15-16, 2016, the facility failed to limit the disclosure of information to an employer or employer-affiliated EAP (Employee Assistance program) to what is permitted in 4 PA Code 255.5 in the following client records.

Client #1 was admitted on 12/14/16 and was still an active client at the time of the inspection. A consent form to an employer, dated 12/4/16, permitted the release of the client's "Preliminary treatment plan, Medical history, Diagnosis, Progress, discharge summary and Aftercare plan".

Client #12 was admitted on 8/3/16 and was still an active client at the time of the inspection. A consent form to an employer-affiliated EAP, dated 8/3/16, permitted the release of the client's "Preliminary treatment plan, Medical history, Diagnosis, Progress, discharge summary and aftercare plan".

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

Plan of Correction

The Medical Records Manager will implement standalone consent forms for employers and employer affiliated EAPs. The new consent form will limit the disclosure of information to an employer or employer affiliated EAP to what is permitted in the PA Code 255.5. The Clinical Director will train all staff on the differentiation between non-affiliated EAPs and employers and affiliated EAPs, disclosure is permitted, and how to complete the new consent form. This will be fully implement by 1/31/2017 which will permit the Clinical Director ample time to train all staff on the new procedure. Employer consents that were implemented for client #1 and client # 2 will be deemed invalid due to be improperly completed. Clients #1 and #2 will be contacted and informed. All consent forms will be monitored by the quality assurance department to ensure this procedure is being adhered to. Quality assurance will forward reports containing any deviations to this procedure to the Clinical Director and Executive Director for additional monitoring.

715.9(a)(4) LICENSURE Intake

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

Observations

Based on a review of client records and a conversation with the facility staff conducted on December 15-16, 2016, the facility failed to comply with the regulation in the following record.

Plan of Correction

The Medical Records Manger in conjunction with the Clinical Director and Director of Nursing has developed new documentation which identifies and documents current physiological addiction to opiates. The Medical Director will meet face-to-face with patients prior to prescribing buprenorphine for the purpose of opiate detoxification.

Client #23 was admitted to the detoxification unit on 7/14/16 and discharged on 7/20/2016. The Physician's Assistant conducted the initial assessment and physical examination, which documented the current opiate addiction, however there was no documentation that the narcotic treatment physician signed off on the assessment or physical exam.

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

Effective 1/23/2017, the Medical Director will sign as acknowledgement that he has assessed for indications of physiological dependence. All intake documentation will be monitored by the quality assurance department to ensure this procedure is being adhered to. Quality assurance will forward reports containing any deviations to this procedure to the Clinical Director and Executive Director for additional monitoring.

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

Based on a review of client records and a conversation with the facility staff conducted on December 15-16, 2016, the facility failed to comply with the regulation in the following record.

Client #23 was admitted to the detoxification unit on 7/14/16 and discharged on 7/20/2016.

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

Plan of Correction

The Clinical Director, and medical records manager reviewed the standards requiring facilities to acquire informed consent prior to administration of Buprenorphine. The medical records developed a new form entitled "Buprenorphine Informed Consent", which requires the patient, and nurse's signature. Nurses on all shifts were trained and educated about providing the proper information to patients prior to taking Buprenorphine, and receiving signed consent from each patient prior to administering the medication. The medical records manager entered the new form in the system on 10/10/2016, and the new procedure for obtaining informed consent started 10/10/2016. The quality assurance manager will monitor case records on a weekly basis to ensure that written informed consent is received from each patient prior to administering the medication. The quality assurance manager will forward reports to the Clinical Director and Executive Director for additional monitoring.

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 client records and a conversation with the facility staff conducted on December 15-16, 2016, the facility failed to comply with the regulation in the following record.

Client #23 was admitted to the detoxification unit on 7/14/16 and discharged on 7/20/16. The Physician's Assistant conducted the initial assessment and physical examination, however there was no documentation that the narcotic treatment physician consulted with the Physician's Assistant prior to the initial dose.

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

Plan of Correction

It is a facility policy for the medical director to conduct an assessment and physical examination prior to the determination of the initial dose of any medication. Effective 1/20/2017 if for any reason it must be conducted by the Physician's assistant, the Physician will review and countersign the assessment and physical examination as acknowledgement. All physical exams and initial assessment will be monitored by the quality assurance department to ensure this procedure is being adhered to. Quality assurance will forward reports containing any deviations to this procedure to the Clinical Director and Executive Director for additional monitoring.

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POCONO MOUNTAIN RECOVERY CENTER, LLC

3437 ROUTE 715
HENRYVILLE, PA 18332

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/12/2018

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on January 9-12, 2018 by staff from the Department of Drug and Alcohol Programs, Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. Based on the findings of the on-site inspection, Pocono Mountain Recovery Center was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.11(a)(3) LICENSURE Training Feedback

704.11. Staff development program. (a) Components. The project director shall develop a comprehensive staff development program for agency personnel including policies and procedures for the program indicating who is responsible and the time frames for completion of the following components: (3) A mechanism to collect feedback on completed training.

Observations
Based on an interview with Employee number 3 on January 10, 2018, the facility was to keep copies of feedback forms completed by employees and develop a report on attended trainings. Employee number 3 indicated that there were no feedback forms on file. These findings were discussed with facilty staff.

Plan of Correction
It is the policy that all staff that attend trainings complete a feedback form on the training. Employee #3 did fail to fill out a feedback form for a training he attended.

On 1/29/18 during a staff meeting, Clinical Director re-trained staff and all staff are required to fill out an evaluation form for any training the attend that also includes, internal trainings, external trainings, web-based training or webinars. The evaluation form that also includes future trainings staff has suggestions on.

Clinical Director and Human Resource Director will monitor monthly to assure compliance by staff in completing training feedback forms. All feedback forms will be placed in personal files.

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

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

Observations
Based on a review of the staffing requirements facility summary (SRFS) report and an interview with human resources on January 9-12, 2018, the facility failed to ensure that staff other than clinical staff completed the mandatory trainings within the first 2 years of employment.The following was noted: Staff #12 was hired on 1/6/2016 and there was

Plan of Correction
Employees #12, #13, #14, and #15 in fact did not attend the required training's within their first 2 years of hiring. The Clinical Director and Human Resource Director will assume the role of auditing employee's training manuals. These manuals will be audited once a month. Therefore, training manuals will have been inspected 12 times annually. This will

no documentation of STD/TB training as of the date of the inspection. Staff # 13 was hired on 1/4/2016 and there was no documentation of STD/TB training as of the date of the inspection. Staff #14 was hired on 6/16/2013 and there was no documentation of HIV/AIDS and STD/TB training as of the date of the inspection. Staff #15 was hired on 8/14/2014 and there was no documentation of HIV/AIDS and STD/TB training as of the date of the inspection.These findings were discussed with facilty staff.This is a repeat deficiency, the facility was previously cited during the licensure inspections conducted on December 16, 2016 and the December 29, 2015.

ensure that all employees have attended not only the necessary training's but also training's required for new employees.

The Clinical Director and Human Resource Director have scheduled STD/TB Trainings and Basic HIV/AIDS trainings for the second week of March 2018 for those who have not attended the required trainings and any new employees hired.

The Clinical Director and Human Resource Director will continue to schedule TB/STD and Basic HIV/AIDS in March and September yearly.

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

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

Observations

Based upon a review of personnel records on January 9, 2018, the facility failed to ensure that clinical staff received the required number of training hours. One out of one counselor records requiring documentation of 25 training hours only had documentation of 20 training hours. These findings were discussed with facilty staff.

Plan of Correction

Beginning 2/01/2018 the Clinical Director and Human Resource Director will meet monthly to keep track of all employees, the number of training hours needed for the year, and number of hours completed. Human Resource Director and Clinical Director will continually check employee training files to ensure staff are attending required trainings. Clinical Director will also remind all staff on training needs throughout the training year, and document any non-compliance issues in their employee record.

704.11(g)(1) LICENSURE Trng Req-Couns Asst

(g) Training requirements for counselor assistants. (1) Each counselor assistant shall complete at least 40 clock hours of training the first year and 30 clock hours annually thereafter in areas such as: (i) Pharmacology. (ii) Confidentiality. (iii) Client recordkeeping. (iv) Drug and alcohol assessment. (v) Basic counseling. (vi) Treatment planning. (vii) The disease of addiction. (viii) Principles of Alcoholics Anonymous and Narcotics Anonymous. (ix) Ethics. (x) Substance abuse trends. (xi) Interaction of addiction and mental illness. (xii) Cultural awareness. (xiii) Sexual harassment. (xiv) Developmental psychology. (xv) Relapse prevention. (h) Training hours. Training hours are not cumulative from one personnel classification to another.

Observations

Based upon a review of personnel records on January 9, 2018, the facility failed to ensure that clinical staff received the required number of training hours. One out of one counselor assistant records requiring documentation of 30 training hours only had documentation of 11 training hours.These findings were discussed with facilty staff.

Plan of Correction

Beginning 02/01/2018 the Clinical Director and Human Resource Director will meet monthly will keep track of all employees, the number of training hours needed for the year, and number of hours completed. Human Resource Director and Clinical Director will continually check employee' training files to ensure staff are attending required trainings. Clinical Director will also remind all staff on training needs throughout the training year, and document any non-compliance issues in their employee record.

705.2 (2) LICENSURE Building exterior and grounds.

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

Observations

Plan of Correction

Based on a physical plant inspection conducted on January 11 & 12, 2018, the facility failed to maintain the grounds of the facility in good repair.The hand railing/post of client Cottage #2 was observed to be deteriorating and had signs of wood rot. The gym floor (sub flooring under the mat) by the weight bench was observed to be damaged, creating a tripping hazard. These findings were discussed with facility staff.

Maintenance Staff was made aware of the handrail outside cottage #2 and repairs were made on 1/14/18.

Maintenance Staff evaluated "Gym" sub floor damage and materials to repair was ordered. Sub-floor repair and completion will be completed by 3/1/18.

Maintenance staff will monitor buildings and grounds daily and report their finding to the CEO for the approval if repairs are needed.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.6 (5) LICENSURE Bathrooms.

705.6. Bathrooms. The residential facility shall: (5) Ventilate toilet and wash rooms by exhaust fan or window.

Observations

During the physical plant tour conducted on January 11, 2018, the exhaust fan in the nurse's bathroom was observed to not be operational. This was the only means of ventilation as there was no window in the bathroom. These findings were discussed with facilty staff.

Plan of Correction

On 1/11/18 during the onsite inspection, it was found that the exhaust fan in the nurse's station was not working. Maintenance Staff was notified and the fan was immediately replaced on 1/11/18. Licensing staff was made aware.

Maintenance staff will monitor buildings and grounds daily and report their finding to the CEO for the approval if repairs are needed.

The Safety will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.6 (6) LICENSURE Bathrooms.

705.6. Bathrooms. The residential facility shall: (6) Provide toilet paper at each toilet at all times.

Observations

During a physical plant inspection on January 11, 2018, it was observed that the bathroom door in Client room 22 had holes in both sides of the door. The holes were the size of a softball on each side of the door. These findings were discussed with the facilty staff.

Plan of Correction

Maintenance Staff was made aware of the findings of DDAP licensure in room #22 and repairs were completed on 1/14/18.

Maintenance staff will monitor buildings and grounds daily and report their finding to the CEO for the approval if repairs are needed.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.6 (7) LICENSURE Bathrooms.

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

Observations

During a physical plant inspection on January 11, 2018, it was observed that the water faucet in client bathroom # 7 would not turn off and was dripping. Thus causing a rust stain in the bathtub and pitting of fixtures. During the same physical inspection, there was a hole the size of a softball observed in the bathroom wall of room #8. These findings were discussed with facilty staff.

Plan of Correction

Maintenance Staff was made aware of the findings of DDAP licensure in room #7 the faucet in the bathroom was replaced and repairs were completed on 1/12/18.

Maintenance Staff was made aware of rust stain in the findings of DDAP licensure in room #7. Rust stains and

fixture was replaced in bathroom and repairs were completed on 1/15/18.

Maintenance Staff was made aware of holes in walls in room #8 in the findings of DDAP licensure visit. Holes were repaired in room #8 completed on 1/15/18

Maintenance staff will monitor buildings and grounds daily and report their finding to the CEO for the approval if repairs are needed.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.10 (a) (1) (ii) LICENSURE Fire safety.

705.10. Fire safety. (a) Exits. (1) The residential facility shall: (ii) Maintain a minimum of two exits on every floor, including the basement, that are separated by a minimum distance of 15 feet.

Observations

During a physical site inspection on January 11, 2018, it was observed that there was storage in the attic of the detox building (there were items such as a Christmas tree, decorations, a toboggan, a microwave and other items). There were not two exits from the detox attic. These findings were discussed with facilty staff.

Plan of Correction

Maintenance was informed that no items are to be stored in the attic and all items were removed and stored appropriately on 1/27/18.

This area will be locked and only maintenance staff will will have access.

PMRC will be submitting for an exemption for this area not having a second exit.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.10 (d) (1) LICENSURE Fire safety.

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

Observations

Based upon a review of the facilty fire drill log, the facilty failed to conduct unannounced fire drills at least once a month. Upon review of the yearly fire drills for 2017, there was no fire drill conducted for the month of November 2017. These findings were discussed with the facilty staff.

Plan of Correction

Safety Officer will conduct unannounced fire drills monthly. Director of Compliance will continue and monitor prior to months end, and ensure all drills are conducted monthly.

705.10 (d) (4) LICENSURE Fire safety.

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

Observations

Based upon review of the facilities fire drill log for the year 2017, there was no documentation of which escape routes were used for any of the fire drills in 2017. These findings were discussed with the facilty staff.

Plan of Correction

Director of Compliance has updated fire drill procedure. Safety Officer was trained on 1/31/18.

New fire drill documentation will indicate, date and time of the drill, evacuation time, exit route used, problems encountered, and what exit was blocked during the drill

All staff will be trained on new drill procedure by 3/1/18 and training will also be a part of orientation for all new

employees.

Director of Compliance will monitor fire drills and documentation to ensure ongoing compliance.

705.10 (d) (5) LICENSURE Fire safety.

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

Observations
Based upon a review of facility fire drill logs for year 2017, the facility failed to conduct a fire drill during sleeping hours at least every 6 months. There was only documentation of one fire drill conducted during sleeping hours, which was on 10/29/2017 at 4:24am. These findings were discussed with the facilty staff.

Plan of Correction
Safety Officer will conduct unannounced fire drills monthly. Director of Compliance will monitor to ensure drills are conducted during sleeping hours at least once every 6 months

705.10 (d) (6) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential facility shall: (6) Prepare alternate exit routes to be used during fire drills.

Observations
During a review of the fire drills conducted during the year 2017, it was not noted which exit routes were used during any of the fire drills that occured. These findings were discussed with the facilty staff.

Plan of Correction
Director of Compliance has updated fire drill procedure. Safety Officer was trained on 1/31/18.

New fire drill documentation will indicate, date and time of the drill, evacuation time, exit route used, problems encountered, and what exit was blocked during the drill

All staff will be trained on new drill procedure by 3/1/18 and training will also be a part of orientation for all new employees.

Director of Compliance will monitor fire drills and documentation to ensure ongoing compliance.

705.10 (d) (7) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential facility shall: (7) Conduct fire drills on different days of the week, at different times of the day and night and on different staffing shifts.

Observations
Based on a review of the facilities fire drill log submitted for the year 2017, the facility failed to vary the days of the week for fire drills. It was noted that there were five fire drills completed on Sundays and five fire drills completed on Mondays. These findings were discussed with the facilty staff.

Plan of Correction
Safety Officer will conduct unannounced fire drills monthly. Safety Officer trained on randomizing drills. Drills will be conducted on different days of the week and on various shifts.

Director of Compliance will monitor fire drills and documentation to ensure ongoing compliance.

705.21 (3) LICENSURE General req. for nonresidential facilities.

705.21. General requirements for nonresidential facilities. The nonresidential facility shall: (3) Comply with applicable Federal, State and local laws and ordinances.

Observations
Based on observation during physical plant inspection on 1/12/18, the facility failed to comply with Federal, State and local laws and ordinances. The facility was not in compliance with the national electrical code. The facility was missing covers on two of the panel boxes in the basement. The facility was missing a junction box cover on the large box located on the baasement wall accross from the stairs to the right of the panel box. The facility was missing a junction box cover on a small junction box located on the left side of the stairs as you come down the stairs. There was an unsecured electrical outlet without a cover hanging from one of the

Plan of Correction
Upon the conclusion of the DDAP licensing visit, maintenance was made aware of the issues and repairs were made. On 1/28/18 ? Panel Boxes were covered and secured.

Upon the conclusion of the DDAP licensing visit, maintenance was made aware of the issues and repairs were made. On 1/28/18 ? junction box was secured along with electrical outlet secured.

joints near the stairs in the basement. These findings were discussed with the facilty staff.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

705.28 (a) (1) (ii) LICENSURE Fire safety.

705.28. Fire safety. (a) Exits. (1) The nonresidential facility shall: (ii) Maintain a minimum of two exits on every floor, including the basement, that are separated by a minimum distance of 15 feet.

Observations

It was observed during the physical site inspection of the outpatient building on 1/12/18 that the basement was being used for storage (Christmas tree, wading pools, table, chairs, etc) and there was only one exit. These findings were discussed with the facilty staff.

Plan of Correction

Maintenance was informed of the issues and all items were removed and stored appropriately on 1/27/18. Access to the basement will be restricted to maintenance personnel.

This area will be remained locked and maintenance staff will have access.

PMRC will be submitting for an exception to DDAP for the second exit.

705.28 (a) (1) (iii) LICENSURE Fire safety.

705.28. Fire safety. (a) Exits. (1) The nonresidential facility shall: (iii) Maintain each ramp, interior stairway and outside steps exceeding two steps with a well-secured handrail and maintain each porch that has over an 18 inch drop with a well-secured railing.

Observations

During a physical site inspection of the outpatient building on 1/12/18, it was noted that the interior stairway going to the second floor had no secured handrail from the landing to the second floor. The original handrail was embedded into the wall. These findings were discussed with the facilty staff.

Plan of Correction

Maintenance staff was made aware and installation of handrail was completed on 1/28/18.

The Safety Committee will also conduct weekly inspections of buildings and grounds to ensure all buildings and grounds are maintained.

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 upon the physical plant inspection the facility failed to ensure that all fire extinguisher were inspected and approved annually. It was observed during a licensing inspection on 1/12/18 of the outpatient building that the fire extinguisher in the basement had been last serviced in 2004/2005. These findings were discussed with the facilty staff.

Plan of Correction

Director of Compliance, Safety Officer and Maintenance Staff was made aware. Fire Extinguisher was replaced on 1/15/18. Safety Officer will ensure all fire extinguishers are inspected yearly. Director of Compliance will monitor to ensure ongoing compliance.

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

Based upon a review of the facility's fire drill log, the facility failed to document the amount of time it took ot evacuate the building or exit routes used. These findings were discussed with the facilty staff.

Plan of Correction

Director of Compliance has updated fire drill procedure. Safety Officer was trained on 1/31/18.

New fire drill documentation will indicate, date and time of the drill, evacuation time, exit route used, problems encountered, and what exit was blocked during the drill. The documentation will also include number

person involved in drill.

All staff will be trained on new drill procedure by 3/1/18 and training will also be a part of orientation for all new employees.

Director of Compliance will monitor fire drills and documentation to ensure ongoing compliance.

709.28 (c) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record.

Observations

During the on site inspection on 1/12/18, the facility was unable to provide a signed consent to release information form releasing information to father other than emergency situations as stated in release form. Progress notes dated 10/11/17 and 10/19/17 show communications with the father discussing progress and after care in the program for client #7D.Client record #8D contained a consent to release information form to the funding source signed by the client; however, the information to be released had not been completed. During the on site inspection on 1/9/18, the facility was unable to provide a signed consent to release information form releasing information to the mother other than emergency situations as stated in the release form. Progress notes show communication with mother discussing after care and progress in the program for client #4R. During the on site inspection on 1/9/18, the facility was unable to provide a signed consent to release information form releasing information to the son other than visitation as stated in the release form. Progress notes show communication with son by counselor pertaining to treatment on 12/20/17 for client #6R. These findings were discussed with facilty staff. This is a repeat deficiency. The facility was previously cited during the licensure inspection conducted on December 16, 2016.

Plan of Correction

The Clinical Director on 2/16/18 will meet with PMRC staff members to provide a training on confidentiality and how to properly complete a consent to release information. This training will continue again every six months from this date. In addition, for staff members who do not attended these trainings they will be required to attend and complete a DDAP approved external training on confidentiality and the application of confidentiality. The Clinical Director and Quality Assurance Coordinator will review client records for accurate and complete consent to release information forms at each site on a weekly basis.

709.82(b) LICENSURE Treatment and rehabilitation services

709.82. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days.

Observations

Based on review of client records the facility failed to ensure that treatment plans were updated at least every 30 days in one of two client records reviewed. Client record 1P contained an initial treatment plan dated 9/5/17. The treatment plan update in the record was completed on 10/16/17. These findings were discussed with facility staff.

Plan of Correction

Clinical Director conducted a training session on 2/05/18 with PHP and Outpatient Clinical Staff on documentation of clinical services that included the standards for treatment plans and treatment plan updates. Also included in this session was how to utilize the calendar section of the electronic charting to prompt counselor staff 2 days prior an updated treatment plan is due. This will ensure the timely implementation of updated treatment plans.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

709.82(c) LICENSURE Treatment and rehabilitation services

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

Observations

During an onsite record review that took place on January 9-12, 2018, the facility failed to provide counseling services in accordance with client 1P's treatment plan.The treatment

Plan of Correction

Clinical Director conducted a training session on 2/05/18 with PHP and Outpatient Clinical Staff on documentation of clinical services. This training included meeting the minimum

plan dated 9/5/17, stated that the client 1P was to have one individual session per week and three group sessions of counseling per week. During the weeks of 9/18/17, 10/2/17 and 10/13/17, client 1P only received group therapy two times a week.These findings were discussed with facility staff.

required individual sessions in accordance with both DDAP requirements and treatment plan. No Shows will be documented in the patient record and an attempt to reschedule missed sessions will be made.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

709.82(d)(1) LICENSURE Treatment and rehabilitation services

709.82. Treatment and rehabilitation services. (d) Counseling shall be provided to a client on a regular and scheduled basis. The following services shall be included and documented: (1) Individual counseling, at least twice weekly.

Observations

Based on a review of client records on January 9-12, 2018, the faciltiy failed to provide individual counseling, at least twice weekly as per the regulations in two of two records reviewed. Treatment plans in client records 1P and 2P only listed one individual session per week. These findings were discussed with facilty staff.

Plan of Correction

Clinical Director conducted a training session on 2/05/18 with PHP and Outpatient Clinical Staff on documentation of clinical services. This training included meeting the minimum required individual sessions in accordance with both DDAP requirements and treatment plan. No Shows will be documented in the patient record and an attempt to reschedule missed sessions will be made.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

709.62(c)(2)(i) LICENSURE Orientation Proj policies

709.62. Intake and admission. (c) Intake procedures shall include documentation of the following: (2) Client orientation to the project which includes, but is not limited to a familiarization with: (i) Project policies, which include the following:

Observations

Based on review of client records January 9-12, 2018, the facility failed to provide communication of client orientation to the project in one of the three client records reviewed. There was no documentation verifying the client was oriented to the project in client record # 8D. These findings were discussed with facility staff.

Plan of Correction

It is the Policy of Pocono Mountain Recovery Center that all patient are orientation to the project. PMRC has immediately implemented "New Patient Orientation Group" be conducted 3 times weekly, (Monday, Wednesday and Friday). This will ensure that all new patient's entering treatment will be orientated to the program. All new patient's will be required to sign and orientation sheet that will be scanned into their electronic chart.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

709.53(a)(11) LICENSURE Follow-up information

709.53. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following: (11) Follow-up information.

Observations

During onsite inspection on January 12, 2018, facility was unable to provide documentation that a follow up call was made to the phone number provided on the face sheet for the client #3. These findings were discussed with facility staff.

Plan of Correction

To adhere to this standard the PMRC on 02/01/2018 PMRC case manager was trained to conduct follow-up phone calls and the documentation needed. To ensure the accuracy of information provided by the patient, case manager will meet with patients prior to discharge and review information. After discharge case manager will call patients for follow-up information. Clinical Director and Quality Assurance Coordinator will have ongoing monitoring of follow-up to ensue this standard is met.

709.92(c) LICENSURE Treatment and rehabilitation services

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

Observations

Based on a review of client records, the facility failed to ensure that counseling services were provided in accordance with the treatment plan in one of two records reviewed. The treatment plan in client record # 1 O, dated 10/16/17, stated that client # 1 O was to have 1 individual session and 3 group sessions per week. In November, it was documented that client # 1 O received only two individual counseling sessions. One on 11/3/17 and the other on 11/22/17.It was documented that client # 1 O attended group therapy 1 time in the month of November. In December 2017, it was documented that client # 1 O attended one individual counseling session on 12/15/17. Client # 1 O was a no call/no show for 12/1/17, 12/6/17 and 12/22/17. It was documented that client # 1 O attended group twice a week in December. There was no documentation for client # 1 O for the month of January 2018, as of 1/11/18. These findings were discussed with facility staff.

Plan of Correction

Clinical Director conducted a training session on 2/05/18 with PHP and Outpatient Clinical Staff on documentation of clinical services. This training included meeting the minimum required individual sessions in accordance with both DDAP requirements and treatment plan. No Shows will be documented in the patient record and an attempt to reschedule missed sessions will be made.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

709.93(a)(3) LICENSURE Client records

709.93. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to, the following: (3) Record of services provided.

Observations

Based on a review of client records on January 9-12, 2018, the facilty failed to document a record of client services in one of two client records. There was no documented Record of Service for Client # 1 O for the months of October, November, December or January. These findings were discussed with facility staff.

Plan of Correction

Clinical Director conducted a training session on 2/05/18 with PHP and Outpatient Clinical Staff on documentation of clinical services. This training included documentation of client Record of Service. Weekly census meeting will review all charting including Record of Service for missed appointments.

Clinical Director and Quality Assurance Coordinator will monitor charts weekly to assure ongoing compliance with this standard.

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