Pennsylvania Department of Health
Inspection Results

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HABIT OPCO, INC. - ALLENTOWN
4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 09/23/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted on September 21, 2015 through September 23, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc. - Allentown was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

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

Observations
Based on a review of the project's Staffing Requirement Facility Summary Reports (SRFSR), the project failed to have a full-time clinical supervisor for every eight full-time counselors or counselor assistants, or both.The findings inclued:The Staffing Requirements Facility Summary Reports for the 4 facilities contained within the project were reviewed on September 21, 2015. The equivalent of 22 full-time counselors were employed within the project at the time of the inspection. This would require at least 2 full-time clinical supervisor.The project's SRFSRs listed a total of 2 clinical supervisors, who also were listed as counselors and having a full caseload; therefore, they are unable to provide full-time clinical supervision.These findings were reviewed with facility staff during the licensing process.

Plan of Correction
The Center Director will submit a Personnel Action Request to human resources on 10/12/15. This Personnel Action Request being submitted to hire an additional clinician, or counselor assistant. This staffing action will allow for the existing clinical supervisors caseload to be transferred to the new hire, while also ensuring that the counselor?s caseload does not exceed 35:1. When the hiring process is completed, this will create a dynamic for greater supervision and case review by the clinical supervisors, who will carry a caseload of no more than 5 patients. The Center Director will be responsible for ensuring that the action plan is implemented as well as continuously monitor the 8:1 counselor to clinical supervisor ratio, with the clinical supervisor, to ensure that the facility maintains compliance with the regulated ratio.

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

Observations
Based on a review of the facility's Staffing Requirements Facility Summary Report (SRFSR) and a review of the personnel training files, the facility failed to ensure that all personnel received a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum within the regulatory time frames.The findings include:The SRFSR form, completed by the facility, and personnel training files were reviewed on September 21,

Plan of Correction
As of 10/9/15, all newly hired staff will complete HIV/AIDS training within the first year of hire, in accordance with the State regulation. Office Manager will monitor all training requirements on a quarterly basis and report updates to the Clinic Director via a quarterly training report.

2015. The facility failed to provide HIV/AIDS training for one of seventeen staff employed, specifically employee #3.Employee #3 was hired as a counselor on June 16, 2014. HIV/AIDS training and TB/STD and other health related topics trainings were due to be completed no later than June 16, 2015. However, there was no documentation of either training on the SRFSR, as well as in the employee's training file.These findings were reviewed with facility staff during the licensing process.

Employee #3 provided notice of terminating her employment and her scheduled DDAP trainings have been canceled.

709.28(c) LICENSURE Confidentiality

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

Observations

Based on the review of client records, the facility failed to ensure that an informed and voluntary consent to release information was obtained in two of fifteen client records reviewed.The findings included:Fifteen client records requiring complete informed and voluntary consent to release information forms were reviewed on September 21, 2015 through September 23, 2015. The facility failed to ensure that an informed and voluntary consent to release information form was obtained in client records, #8 and 9.Client #8 was admitted into outpatient drug-free treatment on July 17, 2015 and was still an active client at the time of the inspection. There was no client signed/dated consent to release information form for the funding source, prior to the release of information, documented in the client record as of the date of the inspection.Client #9 was admitted into outpatient drug-free treatment on October 30, 2014 and was discharged on February 11, 2015. There was no client signed/dated consent to release information form for the funding source, prior to the release of information, documented in the client record as of the date of the inspection.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

In 2013, the Receipt of Information and Agreement form was updated as a result of changes in Federal Guidelines regarding confidentiality of electronic health records. This form also serves as a consent for billing the funding source. As of 10/9/15, all admissions, inclusive of Drug-Free outpatient, will sign this form upon admission. This will ensure proper consent is obtained and documented in the EMR.

1. The patients in question have since been discharged from the program.

2. The intake counselor will ensure all patients, inclusive of drug-free admissions, will have the proper consents signed/dated upon admission.

3 & 4. As of 10/26/15, the Clinical Supervisor will check the EMR upon completion of the intake to ensure the proper documentation has been signed/dated by the patient.

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

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

Observations

Based on a review of client records, the facility failed to document an annual evaluation of the patient in three of fifteen client records reviewed.The findings include:Fifteen client records were reviewed on September 21, 2015 through September 23, 2015. Thirteen client records pertained to the narcotic treatment program and of the thirteen client records, eight client records required documentation of an annual evaluation. The facility failed to have an annual evaluation documented by the counselor in client records, #11, 12, and 14.Client #11 was admitted into the narcotic treatment program on September 15, 2010 and was discharged on June 15, 2015. The last documented clinical annual evaluation in the client chart was dated 09/21/2011. There was no other annual evaluation in the chart as of the date of the inspection.Client #12 was admitted into the narcotic treatment program on November 8, 2013 and was discharged on January 13, 2015. The clinical annual evaluation was due to be completed on the anniversary date of 11/08/2014; however, there was no annual evaluation in the client chart at the time of the inspection.Client #14 was

Plan of Correction

Beginning 10/9/15, Clinical Supervisor will monitor Annual Evaluations due on a weekly basis in supervision with staff. This will be accomplished by utilizing the Services Due report via the EMR for respective staff. Weekly review of evaluations will be completed by the CS to ensure completion and signatures will be verified.

admitted into the narcotic treatment program on November 25, 2013 and was discharged on June 15, 2015. The clinical annual evaluation was due to be completed on the anniversary date of 11/25/2014; however, there was no annual evaluation in the client chart at the time of the inspection.These findings were reviewed with facility staff during the licensing process.

715.23(d)(2) LICENSURE Patient records

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

Observations

Based on a review of client records, the facility failed to document treatment plan updates within the 60-day regulatory period as required by Chapter 709 in seven of fifteen client records reviewed.The findings include:Fifteen client records were reviewed on September 21, 2015 through September 23, 2015. Thirteen client records pertained to the narcotic treatment program and required 60-day treatment plan updates. The facility failed to document 60-day treatment plan updates in client record #'s 3, 4, 5, 7, 12, 14, and 15.Client #3 was admitted into the narcotic treatment program on July 30, 2012 and was still an active client as of the date of the on-site inspection. Treatment plan updates were completed on 01/28/15, 04/15/15, 5/6/15 and 7/22/15. These treatment plan updates were not completed within the 60-day timeframe as required in Chapter 709.Client #4 was admitted into the narcotic treatment program on December 8, 2008 and was still an active client as of the date of the on-site inspection. Treatment plan updates were completed on 11/07/14, 02/01/15, 04/16/15, 06/29/15 and 09/10/15. These treatment plan updates were not completed within the 60-day timeframe as required in Chapter 709.Client #5 was admitted into the narcotic treatment program on June 4, 2012 and was still an active client as of the date of the on-site inspection. Treatment plan updates were completed on 09/22/14, 12/08/14, 02/05/15, 04/17/15, 05/13/15 and 07/24/15. These treatment plan updates were not completed within the 60-day timeframe as required in Chapter 709.Client #7 was admitted into the narcotic treatment program on March 22, 2015 and was still an active client as of the date of the on-site inspection. The initial treatment plan was completed on 05/05/15 and the first update was completed on 07/22/15. The treatment plan update was not completed within the 60-day timeframe as required in Chapter 709.Client #12 was admitted into the narcotic treatment program on November 8, 2013 and was discharged on January 13, 2015. A treatment plan update was completed on 08/04/14 and the next update was completed on 12/09/14. The treatment plan update was not completed within the 60-day timeframe as required in Chapter 709.Client #14 was admitted into the narcotic treatment program on November 25, 2013 and was discharged on June 15, 2015. A treatment plan update was completed on 12/26/14 and the next update was completed on 04/03/15. The treatment plan update was not completed within the 60-day timeframe as required in Chapter 709.Client #15 was admitted into the narcotic treatment program on April 16, 2014 and was discharged on May 4, 2015. A treatment plan update was completed on 02/05/15 and the next update was due to be completed no later than 04/05/15; however, there was no update documented in the client chart at the time of the inspection.These findings were

Plan of Correction

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

reviewed with facility staff during the licensing process.

709.92(a) LICENSURE Treatment and rehabilitation services

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

Observations

Based on a review of client records, the facility failed to document an individual treatment and rehabilitation plan developed with the client in one of two outpatient drug-free client records reviewed.The findings include:Fifteen client records were reviewed on September 21, 2015 through September 23, 2015; whereas, two client records pertained to outpatient drug-free treatment and both required documentation of the individual treatment plan developed with the client's input. The facility failed to document the comprehensive treatment plan in client record #9.Client #9 was admitted into outpatient drug-free treatment on October 30, 2014 and was discharged on February 11, 2015. The preliminary treatment plan was completed on 10/30/2014 during the intake process. The comprehensive individual treatment and rehabilitation plan was not completed, signed, and dated by the counselor until 02/11/2015, which was the day the client was discharged.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Beginning 10/9/15, all initial comprehensive treatment plans due will be reviewed weekly by the Clinical Supervisor with respective staff. CS will review plans for timeliness and patient input via the EMR. Any issues will be addressed with staff in weekly supervision ongoing.

709.93(a) LICENSURE Client records

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

Observations

Based on a review of client records, the facility failed to document a complete client record on an individual, which includes case consultation notes and follow-up information in one of two outpatient drug-free client records reviewed.The findings include:Fifteen client records were reviewed on September 21, 2015 through September 23, 2015. Two client records pertained to the outpatient drug-free activity, with both records requiring a complete client record. The facility did not provide a complete client record for client record #9.Client #9 was admitted into treatment on October 30, 2014 and was discharged on February 11, 2015. The facility failed to include documentation of case consultation notes and follow-up information in the client record at the time of the inspection.These findings were reviewed with facility staff during the licensing process.

Plan of Correction

Beginning 10/9/15, all required documentation, inclusive of case consults and follow-up will be reviewed weekly by the Clinical Supervisor with respective staff. This will be accomplished by utilizing the Services Due report generated by the EMR. Any issues related to timeliness of submission for any documentation will be addressed/documented in weekly supervision.

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health

Inspection Results

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HABIT OPCO, INC. - ALLENTOWN

4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/28/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on January 16, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, Habit OPCO, Inc. - Allentown was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health

Inspection Results

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

HABIT OPCO, INC. - ALLENTOWN

4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/28/2016

INITIAL COMMENTS

This report is a result of an on-site unusual incident investigation conducted on 1/28/16 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, Habit OPCO, Inc. - Allentown was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health

Inspection Results

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

HABIT OPCO, INC. - ALLENTOWN

4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 01/28/2016

INITIAL COMMENTS

This report is a result of an on-site unusual incident investigation conducted on 1/28/16 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, Habit OPCO, Inc.- Allentown was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health
Inspection Results

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HABIT OPCO, INC. - ALLENTOWN
4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 10/19/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection and methadone monitoring inspection conducted from October 17, 2016 to October 19, 2016 by staff from the Department of Drug and Alcohol Programs, Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. Based on the findings of the on-site inspection, Habit OPCO, Inc. - Allentown was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.5(c) LICENSURE Qualifications for Proj/Fac Dir

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

Observations

Based on a review of personnel records on October 17, 2016, it was determined that the project director did not meet the experiential requirements for the position. Considering the educational attainment of the current project director, he is required to have at least three years of experience in a human service agency, which includes supervision, direct service, and program planning. At the time of the inspection, the project director had no documented experience providing direct services.

Plan of Correction

The Project Director role will be transition to Jonathon Wasp effective 11/14/2016. Mr. Wasp meets all of the qualifications identified in the regulations including direct service. A formal notification will be submitted to the department by Mr. Wasp along with supporting documentation validating his qualifications for the role.

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

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

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

Observations

Based on a review of personnel records and the facility's Staffing Requirement Facility Summary Report (SRFSR) form, the facility failed to ensure that employee's #4 and #7 received the minimum of 6 hours of HIV/AIDS training within the regulatory timeframe.

Employee #4 was hired as a counselor on September 28, 2015 and was due to have the HIV/AIDS training no later than September 28, 2016. There was no documentation in the personnel file of completion of the HIV/AIDS training as of the date of the inspection.

Employee #7 was hired as a counselor on July 7, 2015 and was due to have the HIV/AIDS training no later than July 7, 2016. There was no documentation in the personnel file of the completion of the HIV/AIDS training as of the date of the inspection.

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

Plan of Correction

As of 10/19/16, all newly hired staff will complete HIV/AIDS training within the first year of hire, in accordance with the State regulation. Office Manager will monitor all training requirements on a quarterly basis and report updates to the Clinic Director via a quarterly training report.

Since the inspection, Employees #4 and #7 have been monitoring the DDAP training website weekly, as has the Clinical Supervisor. As soon as the training becomes available, the staff will complete as required and obtain the necessary verification of such. The training will be completed no later than the first available date within our region or neighboring area.

705.22 (2) LICENSURE Building exterior and grounds.

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

Observations

Based on a physical plant inspection on October 18, 2016, it was observed that the facility failed to ensure that the carpets in the large group room downstairs and five counselor offices upstairs were kept in a sanitary and clean manner. The carpeting in each room was dirty and had large stains.

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

Plan of Correction

As of 10/19/16, the carpets in the facility will be professionally cleaned on a quarterly basis. The initial cleaning will occur before the end of Q4 2016 and prior to the end of each quarter thereafter. Receipts will be kept by the Office Manager as verification and can be viewed upon the next site inspection or as requested. The Director will ensure this is conducted quarterly via review of receipts for services.

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

A review of the September 2015 through September 2016 fire drill logs was conducted during the onsite inspection. The facility failed to conduct unannounced drills during the 2016 months of January, February, and March, as well as September 2015. Additionally, there were several fire drill logs that were missing components as follows:

1) Logs for the 2015 months of October, November, and December, as well as logs for the 2016 months of April, May, and June did not include the exit route used and whether a

Plan of Correction

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

Exit route

Number of persons evacuated

Fire alarm/smoke detector operative

fire alarm or smoke detector was operative at the time of the drill.

2) Logs for the 2016 months of April, May, June, July, and September did not include the number of persons evacuated.

3) The log for August 2016 did not include the whether the fire alarm or smoke detector was operative at the time of the drill.

4) The log for July 2016 did not include the time of the drill.

5) The log for September 2016 did not include the exit route used.

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

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

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

709.28 (c) LICENSURE Confidentiality

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

Observations

Based on the review of patient records, the facility failed to document an informed and voluntary consent to release information form prior to the disclosure of information in patient records, #1, 6, 9, and 11. Additionally, patient record #10 had disclosed patient information beyond what the signed consent to release information form permitted.

Patient #1 was admitted on January 25, 2016 and was still an active patient at the time of the inspection. The record did not contain a consent for the funding source, despite evidence that billing was submitted.

Patient #6 was admitted on September 18, 2013 and was still an active client at the time of the inspection. The record did not contain a current consent for the funding source, despite evidence that billing was submitted. The most recent signed consent form expired on January 31, 2016.

Patient #9 was admitted on January 5, 2016 and was active at the time of the inspection. The record did not contain a consent for the funding source, despite evidence that billing was submitted.

Patient #10 was admitted on October 4, 2013 and was discharged on March 1, 2016. A consent form was signed by the patient on February 19, 2016 for another treatment provider that allowed for the release of treatment status-verification and prognosis. However, the record contained documentation of a facsimile sent to the provider on February 19, 2016 which included a treatment plan, dose history, and urinalysis results.

Plan of Correction

All active patients will have signed consent forms for their respective funding source by November 30, 2016 in the EMR. All clinicians will have an additional training regarding confidentiality documented by 11/30/16, inclusive of review of proper disclosures. The Office Manager and the Clinical Supervisor will be responsible for ensuring the consent forms are in the EMR and the clinicians receive the additional training. The Office Manager will provide the Director with notification upon completion.

Patient #11 was admitted on October 20, 2014 and was discharged on October 29, 2015. The record contained documentation of a facsimile sent to another treatment provider that was of the patient's dosing record; however, there was no valid consent to release information form signed by the client prior to the disclosure.

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

715.6(d) LICENSURE Physician Staffing

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

Observations

Based on the review of the physician timesheets for the months of May, June, July, and August 2016, the facility failed to provide at least one hour of physician time a week, on site for every ten patients for each week during May 2016 and June 2016.

During the week of May 8-14, 2016, the patient census was 229. The facility was required to provide at least 22.9 physician hours. There were 7.5 physician hours documented.

During the week of May 15-21, 2016, the patient census was 231. The facility was required to provide at least 23.1 physician hours. There were 18.5 physician hours documented.

During the week of May 22-28, 2016, the patient census was 232. The facility was required to provide at least 27.8 physician hours. There were 18.5 physician hours documented.

During the week of May 29, 2016-June 4, 2016, the patient census was 232. The facility was required to provide at least 23.2 physician hours. There were 11.5 physician hours documented.

During the week of June 5-11, 2016, the patient census was 232. The facility was required to provide at least 23.2 physician hours. There were 22.5 physician hours documented.

During the week of June 19-25, 2016, the patient census was 231. The facility was required to provide at least 23.1 physician hours. There were 22.5 physician hours documented.

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

Plan of Correction

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

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Based on a review of patient records, patient records #1, 2, 3, 5, 6, 7, and 9 had treatment plan updates completed after the regulatory timeframe of 60 days at the time of the

Plan of Correction

Beginning 10/19/16, all treatment plan updates due will be reviewed weekly by the Clinical Supervisor with respective staff. Timeliness of documentation will be monitored and

inspection.

Patient #1 was admitted on January 25, 2016 and was an active patient at the time of inspection. The comprehensive treatment and rehabilitation plan was completed on March 25, 2016. A treatment plan update was due no later than May 25, 2016, but was not completed until June 6, 2016. Additionally, another treatment plan update was due no later than August 6, 2016, but was not completed until October 7, 2016.

Patient #2 was admitted on March 22, 2015 and was an active patient at the time of inspection. A treatment plan update was completed on October 16, 2015, and an update was due no later than December 16, 2016, but was not completed until February 2, 2016. Additionally, another treatment plan update was due no later than April 2, 2016, but was not completed until June 6, 2016.

Patient #3 was admitted on October 26, 2009 and was discharged on September 29, 2016. A treatment plan update was completed on November 24, 2015, and an update was due no later than January 24, 2016, but was not completed until March 23, 2016. Additionally, an update was completed on March 25, 2016 and an update was due no later than May 25, 2016, but was not completed until June 30, 2016.

Patient #5 was admitted on February 27, 2013 and was discharged on May 31, 2016. A treatment plan update was completed on February 15, 2016 and an update was due no later than April 15, 2016, but was not completed until April 27, 2016.

Patient #6 was admitted on September 18, 2013 and was an active patient at the time of inspection. A treatment plan update was completed on June 20, 2016 and an update was due no later than August 20, 2016, but was not completed until September 6, 2016.

Patient #7 was admitted on May 25, 2016 and was discharged on September 28, 2016. The comprehensive treatment and rehabilitation plan was completed on June 25, 2016. A treatment plan update was due no later than August 25, 2016, but was not completed until September 12, 2016.

Patient #9 was admitted on January 5, 2016 and was an active patient at the time of inspection. A treatment plan update was completed on April 22, 2016 and the next update was due no later than June 22, 2016, but the update was not completed until July 27, 2016.

addressed in supervision weekly as well. Clinical Supervisor will generate weekly reports via the EMR system to monitor and address issues accordingly.

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

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health
Inspection Results

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HABIT OPCO, INC. - ALLENTOWN
4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 06/16/2017

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on June 16, 2017 by staff from the Division of Accountability and Program Improvement. Based on the findings of the complaint investigation, Habit OPCO, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

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
On June 16, 2017 DDAP staff reviewed reports generated by the SMART system. The facility failed to provide sufficient dispensing staff to ensure that all patients are medicated within 15 minutes of arrival at the dispensing area."Patient Wait Time Reports" were reviewed for the months of April 2017 and May 2017. During the month of April 2017, 19% of the clients dosed at the facility waited more than 15 minutes to receive their medication. During the month of May 2017, 27% of the clients dosed at the facility waited more than 15 minutes to receive their medication.

Plan of Correction
After review, the variables contributing to the percentages noted would indicate that patients are medicating in a timely manner. However, there are steps to take to ensure this is consistent.

Facility take-home requirements will be re-evaluated by the Director to align with the State requirements for such. Qualified patients will receive the maximum number permitted by the MD and the guidelines, which will reduce the total number of patients medicating on various days of the week, particularly weekends when medicating hours are reduced.

Acadia is relocating this facility in 2018. This will allow for additional dispensing stations and nursing staff, which will also reduce the wait time of individual patients.

Program Manager will facilitate a physical time study to determine the average wait-time of those medicating over the 5 hour window available to do so.

Return to Pennsylvania Department of Health Home Page

Pennsylvania Department of Health
Inspection Results

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

HABIT OPCO, INC. - ALLENTOWN
4400 SOUTH CEDARBROOK ROAD
ALLENTOWN, PA 18103

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 11/28/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on November 27-28, 2017 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, Habit OPCO, Inc.-Allentown, 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 administrative paperwork and a review of employee records conducted on November 27, 2017, the facility failed to ensure that a counselor received the required HIV/Aids trainings within one year of hire date.

Employee #7 was hired as a counselor on 5/2/2016. The HIV/Aids training was to be completed by 5/2/2017 but was not documented at the time of the inspection.

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

Plan of Correction

As of 12/22/17, all newly hired staff will complete HIV/AIDS training within the first year of hire, in accordance with the State regulation. Assistant Director will monitor all training requirements on a quarterly basis and report updates to the Clinic Director via a quarterly training report.

As of 11/9/17, Employee #7 has completed the HIV/AIDS training.

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

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

Observations

Based on a review of administrative paperwork and a review of employee files conducted on November 27, 2017, the facility failed to ensure that two counselors received the required 25 training hours for the 2016 training year.

Training files were reviewed for the training year from

Plan of Correction

Beginning 1/1/2018, training hours for all staff will be documented by the Assistant Director, via a formalized quarterly training report, and reviewed by the Director quarterly. Staff will be required to complete 8 hours per quarter to ensure 25 hours will be completed by the end of the calendar year. In addition, the Clinical Supervisor will

January 1, 2016 through December 31, 2016.

Employee #5 had 7 documented training hours.

Employee #6 had 11.25 documented training hours.

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

provide one 2 hour in-house training per quarter to aid in the staff development throughout the year.

704.12(a)(6) LICENSURE OutPatient Caseload

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

Observations

Based on a review of the Staffing Requirements Facility Summary Report conducted on November 27, 2017, the facility failed to ensure that employees #2, 5, 6 & 7 did not exceed 35 active clients.

Employee #2 works 37.5 hours and has 44 clients yielding a ratio of 41:1.

Employee #5 works 37.5 hours and has 44 clients yielding a ratio of 41:1.

Employee #6 works 37.5 hours and has 49 clients yielding a ratio of 46:1.

Employee #7 works 37.5 hours and has 46 clients yielding a ratio of 43:1.

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

Plan of Correction

As of 12/22/17, Facility Director has hired two additional staff to correct the issue of ratio compliance. Based on the current census and those who meet the criteria of licensure alert 01-14, the facility will meet the 35:1 requirement. The Clinical Supervisor will monitor ratio weekly, when assigning new admissions to counselors. The Facility Director will monitor census weekly to ensure compliance with this regulation and hire additional staff as needed.

709.28 (b) LICENSURE Confidentiality

§ 709.28. Confidentiality. (b) The project shall secure hard copy client records within locked storage containers. Electronic records must be stored on secure, password protected data bases.

Observations

Based on a physical plant inspection conducted on November 27, 2017, the facility failed to ensure the confidentiality of client records.

A filing cabinet in the first-floor group room was unable to be locked securely and contained group sign-in sheets that, in some cases, clients had written their full names instead of their initials.

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

Plan of Correction

As of 11/29/17, the filing cabinet in question was fixed with an external pad lock to ensure the confidentiality of client records. In addition, Staff was educated as to the importance of monitoring the sign-in sheets with each appointment and having the patients document only their initials each session or group. Sign-in sheets will be reviewed by the Clinical Supervisor and/or Office Manager monthly to ensure compliance.

709.30 (1) LICENSURE Client rights

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

Observations

Facility policy and procedure manual was reviewed on November 27, 2017. The facility's policy failed to include the following elements with regard to client rights:

Plan of Correction

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

To inspect their own records, in the presence of the CTC

(3) Clients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record.

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

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

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

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

Director/designee. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record.

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

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

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

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

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

715.6(d) LICENSURE Physician Staffing

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

Observations

Based on a review of administrative documents and a review of the physician's schedule hours conducted on November 27, 2017, the facility failed to provide narcotic treatment physician services at least 1 hour per week onsite for every ten patients.

A schedule was submitted that indicated the hours worked for the physician and the physician extender staff, as well as the patient census, for the weeks from June 4, 2017 through September 30, 2017. The facility was not in compliance for the following weeks:

June 18-24, 2017: census 235, coverage 20 hours

July 2-8, 2017: census 234, coverage 20 hours

August 13-19, 2017: census 231, coverage 20 hours

August 20-26, 2017: census 228, coverage 19 hours

September 3-9, 2017: census 221, coverage 18.5 hours

September 17-23, 2017: census 218, coverage 19.5 hours

September 24-30, 2017: census 218, coverage 19.5 hours

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

Plan of Correction

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

715.19(1) LICENSURE Psychotherapy services

A narcotic treatment program shall provide individualized psychotherapy services and shall meet the following requirements: (1) A narcotic treatment program shall provide each patient an average of 2.5 hours of psychotherapy per

month during the patient 's first 2 years, 1 hour of which shall be individual psychotherapy. Additional psychotherapy shall be provided as dictated by ongoing assessment of the patient.

Observations
Seven client records were reviewed on November 28, 2017, four of which were methadone client records; the facility failed to provide the required one hour of individual therapy per month to client #1.

Client #1 was admitted on 9/26/17 and was an active client at the time of the licensing inspection. Client #1 received only 30 minutes of individual counseling during the month of October 2017.

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

Plan of Correction
As of 12/22/17, the Clinical Supervisor will monitor direct services provided monthly to ensure all active patients are receiving the mandatory 2.5 hours of clinical services. In addition, all staff will be educated in supervision as to the importance of documenting all "no show" notes, in an effort to demonstrate the attempt to engage patients in weekly sessions and/or groups.

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
Seven client records were reviewed on November 28, 2017, four of which were methadone client records; the facility failed to develop the comprehensive treatment plan with clients #2 & 5.

Client #2 was admitted on 3/23/17 and was an active client at the time of the licensing inspection. A comprehensive treatment plan was documented on 4/23/17 however it was not signed by the client until 7/11/17.

Client #5 was admitted on 2/20/17 and discharged on 9/15/17. A comprehensive treatment plan was documented on 4/5/17 however it was not signed by the client and there was no documentation that it had been developed with the client.

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

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

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

Observations
Seven client records were reviewed on November 28, 2017, four of which were methadone client records; the facility failed to specify the type and frequency of treatment on the comprehensive treatment plan in client records #2, 4, 5 & 7.

Client #2 was admitted on 3/23/17 and was an active client at the time of the licensing inspection. The comprehensive treatment plan was documented on 4/23/17.

Client #4 was admitted on 1/23/17 and discharged on 7/18/17. The comprehensive treatment plan was documented on 2/27/17.

Client #5 was admitted on 2/20/17 and discharged on 9/15/17. The comprehensive treatment plan was documented on 4/5/17.

Client #7 was admitted on 12/13/16 and discharged on 9/5/17. The comprehensive treatment plan was documented

Plan of Correction
The Clinical Supervisor will conduct a treatment plan training with all Counselors by 1/31/18. The staff will be re-educated on the appropriate comprehensive plan format, inclusive of specifying type and frequency of treatment, as well as the importance of timely documentation of all treatment plans and updates.

on 1/13/17.

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

709.92(b) LICENSURE Treatment and rehabilitation services

709.92. Treatment and rehabilitation services. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 60 days.

Observations

Seven client records were reviewed on November 28, 2017, four of which were methadone client records; the facility failed to update the treatment plan every 60 days in client records, #2, 3, 4, 5 & 7.

Client #2 was admitted on 3/23/17 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 6/23/17; a treatment plan update was due by 8/23/17 but was not documented until 10/30/17.

Client #3 was admitted on 4/25/11 and was an active client at the time of the licensing inspection. A treatment plan update was documented on 12/30/16; a treatment plan update was due by 3/1/17 but was not documented until 3/3/17. Additionally, a treatment plan update was documented on 4/28/17; a treatment plan update was due by 6/28/17 but was not documented until 7/14/17 and another update was due by 9/14/17 but was not documented until 9/22/17.

Client #4 was admitted on 1/23/17 and discharged on 7/18/17. A comprehensive treatment plan was documented on 2/27/17; a treatment plan update was due by 4/27/17 but was not documented until 5/1/17.

Client #5 was admitted on 2/20/17 and discharged on 9/15/17. A treatment plan update was documented on 5/26/17; a treatment plan update was due by 7/26/17 but was not documented until 7/28/17.

Client #7 was admitted on 12/13/16 and discharged on 9/5/17. A treatment plan update was documented on 3/6/17; a treatment plan update was due by 5/6/17 but was not documented until 5/22/17 and another update was due by 7/22/17 but was not documented until 7/31/17.

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

Plan of Correction

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

Return to Pennsylvania Department of Health Home Page