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Statement of Deficiency

MEDICATION-ASSISTED TREATMENT - OPIOID TREATMENT PROGRAM
INITIAL LICENSURE SURVEY
JANUARY 30, 2017-FEBRUARY 3, 2017

PROGRAM CENSUS: 237
SAMPLE SIZE: 22

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure the administrator of the opioid treatment program is responsible for maintaining documentation regarding the medical director's training and experience in a file which is current and readily available at all times. The administrator also is responsible for ensuring that the plan of development is completed within the approved time lines. Staff affected: one (1) of one (1) medical director of the program. Staff identifier: G. Findings include:

(a) Review of Staff G's, medical director, personnel file revealed no documented evidence of training or experience that was current or readily available.

(b) Interview on 02/01/17 at 1:00 p.m. with Staff A, clinic director, confirmed there was no documented evidence in Staff G's, medical director, personnel file of training or experience that was current or readily available.

(c) The failure of the program administrator to maintain a current and readily available personnel file for Staff G, medical director, does not meet the intent of the regulation to ensure the administrator of the opioid treatment program is responsible for maintaining documentation regarding the medical director's training and experience in a file which is current and readily available at all times. The administrator also is responsible for ensuring that the plan of development is completed within the approved time lines.

Statement of Deficiency

(1) Based on documentation review, observation and interview, the Program failed to ensure that the Opioid Treatment Program may employ and use program physicians, physician extenders and other health care professionals working within their scope of practice who have received sufficient education, training, experience or any combination thereof, to enable the health care professional to perform the assigned functions. All physicians, nurses and other licensed professional care providers must comply with the credentialing requirements of their respective professions. Staff affected: one (1) of seven (7) in the sample. Staff identifiers: E. Findings include:

(a) Observation on 01/31/17 between 10:30 a.m. and 11:00 a.m. revealed Staff E, lab technician, acquired and documented the blood pressure and pulse rate of a patient. Continued observation revealed Staff E, lab technician, provided medication education for a patient intake.

(b) Review of Staff E's, lab technician, job description revealed the job requires only a high school education and did not list any job tasks associated with nursing processes such as blood pressure and pulse checks and patient education on medications.

(c) Interview on 01/31/17 at 11:00 a.m. with Staff A, clinic director, confirmed Staff E, lab technician, was practicing outside his scope of practice for the patient intake process such as blood pressure, pulse checks and medication education intake paperwork.

(d) The practice of the Program to allow staff to function outside of their written job description does not meet the intent of the regulation to ensure that the opioid treatment program employs and uses program physicians, physician extenders and other health care professionals working within their scope of practice who have received sufficient education, training, experience or any combination thereof, to enable that person to perform the assigned functions. All physicians, nurses and other licensed professional care providers must comply with the credentialing requirements of their respective professions.

Statement of Deficiency

(1) Based on observation and interview, the Program failed to ensure during all hours of operation, every opioid treatment program shall have present and on duty at least one of the following actively-licensed health care professionals: program physician, physician extender or registered nurse. Patients affected: all patients treated by the program. Findings include:

(a) Observation on 01/31/17 at 6:30 a.m. revealed no actively-licensed health care professional was present during the medication dosing of patients.

(b) Observation on 02/01/17 at 5:45 a.m. revealed no actively-licensed health care professional was present during the medication dosing of patients.

(c) Observation on 02/02/17 between 6:30 a.m. and 3:15 p.m. revealed no actively-licensed health care professional was present during the medication dosing of patients.

(d) Observation on 02/03/17 between 6:45 a.m. and 3:30 p.m. revealed no actively-licensed health care professional was present during the medication dosing of patients.

(e) Interview on 02/01/17 at 10:00 a.m. with Staff A, clinic director, confirmed there is not always an actively-licensed health care professional on duty during medication dosing of patients. Further interview revealed no actively-licensed health care professional is on duty Wednesdays, Thursdays, Saturdays or Sundays.

(f) Interview on 02/01/17 at 12:30 p.m. with Staff G, medical director, confirmed she only works at the Program on Mondays and Tuesdays between 6:30 a.m. and 3:00 p.m.

(g) The failure of the Program to ensure an actively-licensed health care professional is present during medication dosing of patients does not meet the intent of the regulation to ensure during all hours of operation every opioid treatment program shall have present and on duty at least one of the following actively-licensed health care professionals: program physician, physician extender or registered nurse.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure an opioid treatment program may employ unlicensed clinical staff and utilize volunteers to assist in the operation of the program and facility. The Program shall develop and implement policies and procedures which specify the roles and responsibilities of each unlicensed employee and volunteer. Documentation of the responsibilities, training and other obligations of an unlicensed clinical staff employee or volunteer shall be included in the personnel file of the employee or volunteer. Patient affected: all patients treated by the Program. Findings include:

(a) Review of the policy and procedure manual of the Program revealed no documented evidence of a policy that specified the roles and responsibilities of each unlicensed employee and volunteer.

(b) Interview on 02/03/17 at 3:00 p.m. with Staff A, clinic director, confirmed the Program has no policy that specifies the roles and responsibilities of each unlicensed employee and volunteer.

(c) The failure of the Program to ensure a policy is developed and implemented that specifies the roles and responsibilities of each unlicensed employee and volunteer does not meet the intent of the regulation to ensure an opioid treatment program may employ unlicensed clinical staff and utilize volunteers to assist in the operation of the program and facility. The Program shall develop and implement policies and procedures which specify the roles and responsibilities of each unlicensed employee and volunteer. Documentation of the responsibilities, training and other obligations of an unlicensed clinical staff employee or volunteer shall be included in the personnel file of the employee or volunteer.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure each opioid treatment program shall maintain confidential individual personnel files for every clinical staff member or volunteer, that shall contain, at a minimum documentation related to performance,

supervision, disciplinary actions and termination summaries. Staff affected: two (2) of seven (7) staff in the sample. Staff identifiers: F and G. Findings include:

(a) Review of Staff F's, counselor, hired 10/10/16, personnel file revealed no documented evidence of a 90-day performance evaluation.

(b) Review of Staff G's, medical director, personnel file revealed the last performance evaluation was completed on 07/24/15.

(b) Review of the Program's employee handbook, Page 11, revealed that performance evaluations will occur 90 days after date of hire or change of position and annually.

(c) Interview on 02/01/17 at 1:00 p.m. with Staff A, clinic director, confirmed no 90-day evaluation had been completed for Staff F, counselor. Further interview confirmed no current evaluation had been completed for Staff G, medical director.

(d) The failure of the Program to complete Staff F and G's performance evaluations according to their written policy does not meet the intent of the regulation to ensure each opioid treatment program shall maintain confidential individual personnel files for every clinical staff member or volunteer, that shall contain, at a minimum documentation related to performance, supervision, disciplinary actions and termination summaries.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to maintain all meetings, test results and discussions shall be documented in the patient's chart and individualized treatment of care, along with the individual's decision whether to continue medications at current levels or to begin a slow titration process. Patients affected: 20 of 22 patients in the sample. Patient identifiers: #1 through #19 and #21. Findings include:

(a) Review of Patient #1 through #19 and #21's medical record revealed no documented evidence of all meetings, test results and discussions in the individualized treatment of care, including the patient's decision on medication titration.

(b) Interview on 02/03/17 at 3:00 p.m. with Staff A, clinic director, confirmed there was no documented evidence of all meetings, test results and discussions in the individualized treatment of care, including the patient's decision on medication titration for Patient #1 through #19 and #21.

(c) The failure of the Program to maintain individualized treatment of care that includes all meetings, test results, discussions and patient's decision on medication titration does not meet the intent of the regulation to maintain all meetings, test results and discussions that shall be documented in the patient's chart and individualized treatment of care, along with the individual's decision whether to continue medications at current levels or to begin a slow titration process.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure patient records contain medical reports including the results of the physical assessment; family medical history; review of systems; laboratory reports, including results of required drug screens; results obtained from the Controlled Substances Monitoring Program database; and progress notes, including documentation of current dose and other dosage data. Patients affected: nine (9) of 22 patients in the sample. Patient identifiers: #2, #5, #8, #9, #10, #11, #16, #17 and #18. Findings include:

(a) Review of Patient #2, #5, #8, #9, #10, #11, #16, #17 and #18's medical records revealed no documented evidence of laboratory reports.

(b) Interview on 02/02/17 at 2:00 p.m. with Staff H, nursing supervisor, confirmed the missing lab work in Patient #2, #5, #8, #9, #10, #11, #16, #17 and #18's medical records.

(c) The failure of the Program to maintain laboratory reports in patient's individual medical records does not meet the intent of the regulation to ensure medical reports include results of the physical assessment; family medical history; review of systems; laboratory reports, including results of required drug screens; results obtained from the Controlled Substances Monitoring Program database; and progress notes, including documentation of current dose and other dosage.

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(a) Review of Patient #2, #5, #8, #9, #10, #11, #16, #17 and #18's medical records revealed no documented evidence of laboratory reports.

(b) Interview on 02/02/17 at 2:00 p.m. with Staff H, nursing supervisor, confirmed the missing lab work in Patient #2, #5, #8, #9, #10, #11, #16, #17 and #18's medical records.

(c) The failure of the Program to maintain laboratory reports in patient's individual medical records does not meet the intent of the regulation to ensure medical reports include results of the physical assessment; family medical history; review of systems; laboratory reports, including results of required drug screens; results obtained from the Controlled Substances

Monitoring Program database; and progress notes, including documentation of current dose and other dosage.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure individual patient records shall contain the initial and post-admission individualized treatment plans of care, and any amendments, reviews or changes to the plans. Patients affected: 20 of 22 patients in the sample. Patient identifiers: #1 through #19 and #21. Findings include:

(a) Review of Patient #1 through #19 and #21's medical record revealed no documented evidence of individualized treatment plans of care including amendments, reviews or changes to the plans.

(b) Review of the Program's policy and procedure manual, "7.1.4 Counseling-Documentation Timelines (WV)," Page 211 and 212, identifies initial, seven (7) days, 30 days, and 90 day individualized treatment plans of care documentation.

(c) Interview on 02/03/17 at 3:00 p.m. with Staff A, clinic director, confirmed there was no documented evidence of individualized treatment plans of care, including amendments, reviews or changes to the plans for Patient #1 through #19 and #21's medical records.

(d) The failure of the Program to document individualized treatment plans of care including amendments, reviews or changes to the plans for patient medical records does not meet the intent of the regulation to ensure individual patient records shall contain the initial and post-admission individualized treatment plans of care, and any amendments, reviews or changes to the plans.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure individual patient records shall contain consent forms, releases of information, prescription documentation, travel, employment and "take-home" documentation. Patients affected: two (2) of two (2) patients in the sample for which HIV laboratory work was completed. Patient identifiers: #7 and #16. Findings include:

(a) Review of Patient #7 and #16's medical records revealed a document titled "Consent for HIV Screening" for which both patients marked "Decline the Screening."

(b) Review of Patient #7 and #16's medical records revealed "completed HIV laboratory work" was completed the same date as the signed, declined screenings.

(c) Interview on 02/02/17 at 2:00 p.m. with Staff H, nursing supervisor, confirmed HIV lab testing was completed on Patient #7 and #16 who had not provided written consent.

(d) The failure of the Program to obtain consents prior to completing lab work for patients does not meet the intent of the regulation to ensure individual patient records shall contain consent forms, releases of information, prescription documentation, travel, employment and "take-home" documentation.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure the initial post-admission assessment shall consist of a medical assessment and include documentation of a screening for syphilis. Patients affected: seven (7) of 22 patients in the sample. Patient identifiers: #2, #5, #8, #9, #10, #11 and #17. Findings include:

(a) Review of Patient #2, #5, #8, #9, #10, #11 and #17's medical records revealed no documented evidence of testing for syphilis.

(b) Interview on 02/02/17 at 2:00 p.m. with Staff H, nursing supervisor, confirmed there was no documented evidence of syphilis testing for Patient #2, #5, #8, #9, #10, #11 and #17.

(c) The failure of the Program to provide documented evidence of syphilis testing for patients does not meet the intent of the regulation to ensure the initial post-admission assessment shall consist of a medical assessment and include documentation of a screening for syphilis.

Statement of Deficiency

(1) Based on documentation review and interview, the Program failed to ensure the initial post-admission assessment shall consist of a medical assessment and include documentation of a hepatitis C test. Patients affected: eight (8) of 22 patients in the sample. Patient identifiers: #2, #5, #8, #9, #10, #11, #12 and #17. Findings include:

(a) Review of Patient #2, #5, #8 #9, #10, #11, #12 and #17's medical records revealed no documented evidence of testing for hepatitis C.

(b) Interview on 02/02/17 at 2:00 p.m. with Staff H, nursing supervisor, confirmed there was no documented evidence of hepatitis C testing for Patient #2, #5, #8, #9, #10, #11, #12, and #17.

(c) The failure of the Program to provide documented evidence of hepatitis C testing for patients does not meet the intent of the regulations to ensure the initial post-admission assessment shall consist of a medical assessment and include documentation of a hepatitis C test.