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Z 0000 INITIAL COMMENTS

At the time of the relicensure survey, it was determined that Medicine Wheel Clinic-Winder was not in substantial compliance with the Rules and Regulations for Narcotics Treatment Programs , and the following deficiencies were cited.

Z 0923 290-9-12-.09(8) ADMINISTRATION

Personnel Records. A program shall maintain written and verified records for each employee. Each employee file shall include:

(a) Identifying information including name, current address, current telephone number, and emergency contact persons;
(b) A five-year employment history or a complete employment history if the person has not worked five years;
(c) Evidence of a criminal record check obtained from law enforcement authorities that reflects the individual does not have a recent criminal history within the previous two years and that does not disqualify the individual from providing care to patients;

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(d) Records of educational qualifications if applicable;
(e) Date of employment;
(f) The person's job description or statements of the person's duties and responsibilities;
(g) Documentation of training and orientation required by these rules;
(h) Any records relevant to the employee's performance, including an appropriate health status of the employee; and
(i) Evidence that any professional license required as a condition of employment is current and in good standing.

This Requirement is not met as evidenced by:

Based on review of personnel files and staff interview, it was determined that the facility failed to provide complete personnel records for five of six sampled employees (#1, #2, #4, #5, and #6). The findings were:

A review of personnel files on 08/17/2011 revealed the following:

1. Two of six personnel files (employee 2 #and #6) had no job description. An unsigned job description or a job description not dated was found for two of six employees (#1 and #4).

2. One of six personnel files (#1) did not have an updated annual job performance.

3. Two of six personnel files (#1 and #5) had no documentation of at 16 hours of annual training.

4. Three of six personnel files (#1, #5, and #6) had no documentation of emergency contact information .

5. Six of six personnel files (#1-#6) had no documentation that references were checked.

During an interview with the administrator on 08/17/2011 at 1:00 p.m., he/she confirmed the above findings.

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Z 1100 290-9-12-.11(1) PHYSICAL PLANT AND SAFETY

A program shall be in compliance with all applicable local health, safety, sanitation, building, and zoning requirements.

This Requirement is not met as evidenced by:

Based on review of facility documents and staff interview, it was determined that facility failed to have a pest control and fire extinguisher contract.

A review of documents from the facility on 08/18/2011, revealed that the facility doesn't have a pest control contact, as well as contract to have the fire extinguisher checked annually. The surveyor observed an ant problem in the office upstairs.

During an interview with the administrator on 08/18/2011 at 1:30 p.m., he/she confirmed that the facility did not have a contract for pest control or to check the fire extinguisher.

Z 1102 290-9-12-.11(3) PHYSICAL PLANT AND SAFETY

All buildings and grounds must be accessible by the disabled and constructed and maintained in a safe manner in accordance with these rules.

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This Requirement is not met as evidenced by:

Based on an environmental tour of the facility on 08/18/2011, with staff, it was determined that the facility failed to make sure the building and grounds are maintained in a safe manner. The findings were

A environmental tour at the facility on 08/18/2011 revealed the following:

1. A flood light is needed on the building (handicap assessable side).

2. A door frame needs to be removed from the deck in back.

3. Vinyl siding on the building is hanging down from the building.

During an interview with the administrator at 1:35 p.m. on 08/18/2011, he/she confirmed the above findings.

Z 1213 290-9-12-.12(1)(b)5. PATIENT SCREENING, ASSESSMENT, & ADMISSION

Assessment. ... The [patient] assessment must include:

5. A physical examination in accordance with current and accepted standards of medical practice, complete with laboratory tests, including drug screens, HIV status (if the applicant consents to be tested), CBC and chemistry profile, and pregnancy, STD, and Mantoux TB tests, to determine dependence on opium, morphine, heroin, or any derivative or synthetic drug of that group and to determine current DSM diagnosis. The purpose of such assessments shall be to determine whether narcotic substitution, short-term detoxification, long-term

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detoxification, or drug-free treatment will be the most appropriate treatment modality for the patient and to establish additional educational, vocational, and treatment needs of the patient. In lieu of a complete physical examination being performed by the program physician, the individual may present a complete physical examination, dated within 90 days of admission, performed by a physician licensed in good standing in the State of Georgia. Such
examination shall be updated as necessary to reflect the individual's current condition at the time of admission, including updated laboratory tests.

This Requirement is not met as evidenced by:

Based on review of client records and interview with staff, it was determined that the program failed to ensure that the clients had complete assessments and lab work for two of six sampled clients (#5 and #6). The findings were:

A review of client records on 08/17/2011, revealed that two of six clients (#5 and #6) had no documentation of having tuberculosis (TB) screenings or the TB screening was not given at the time of admission.

During an interview with the administrator on 08/17/20111 at 12:45 p.m., he/she confirmed the above findings.

Z 1302 290-9-12-.13(b) INDIVIDUAL TREATMENT PLAN

In recognition of the varied medical needs of patients, the case history and individual treatment plans must be reviewed at least every 90 days for patients in treatment less than one year and at least annually for patient in treatment more that one year. This review will be conducted by the medical director or program physician along with the primary counselor and other appropriate members of the treatment team for general quality controls and evaluation of the appropriateness of continuing the form of treatment on an on-going basis. This review must also include an assessment of the current dosage and schedule and the rehabilitative progress of the patient, as part of determination of whether additional medical services are indicated. If such review results in a determination that additional or different medical services are
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This Requirement is not met as evidenced by:

Based on review of patient records and interviews, it was determined that the facility failed to ensure that a 90 day review of individual treatment plans (ITP) reflect or include the goals and objectives from the (ITP) for five of six sampled patients (#1-#4, and #6). The findings were:

A review of patient records on 08/18/2011, revealed that five of six patients' 90 day reviews failed to show progress or lack of progress of the goals or objectives from the individual treatment plans.

During an interview on 08/18/2011 with the administrator at 1:00 p.m., he/she confirmed the above findings.

Z 1304 290-9-12-.13(d) INDIVIDUAL TREATMENT PLAN

As part of the rehabilitative services provided by the program, each patient must be provided with individual or group counseling appropriate to his or her needs. The frequency and duration of counseling provided to patients must be determined by appropriate program staff and be consistent with the individual treatment plan. Individual treatment plans must indicate a specific level of counseling services needed by the patient as part of the rehabilitative process.

This Requirement is not met as evidenced by:

Based of review of patient records and staff interviews, it was determined that the facility failed to ensure that each patient was provided group counseling as part of their rehabilitative process for five of six sampled patients (#2-#6). Six of six patients' individual treatment plans did not have the duration and frequency of individual or group counseling appropriate to the patients' needs, and the individual treatment plan (ITP) goals and objectives, or did not indicate a specific level of counseling services needed by the patients as part of the rehabilitative process (#1-#6) . The findings were:

A review of patient records on 08/18/2011, revealed that five of six patients' records had no documentation, in the individual treatment plan (ITP) or progress notes, that patients were

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provided group counseling.

A review of patient records also revealed that six of six patients' (ITPs did not contain the duration or frequency of individual or group counseling. The ITP did not have specific days or how often individual or group counseling would be offered to the patients, and the counseling sessions (in the case notes) did not reflect the goals and objectives from the ITP. The ITP goals and objectives did not address coping skills, identifying triggers, or goals/objectives that address specific needs or issues of the patients.

During an interview on 08/18/2011 at 12:55 p.m. with the administrator, he/she confirmed that the facility needs to offer group counseling to the patients, and the case notes should reflect or include the goals and objectives from the individual treatment plans.

Z 1703 290-9-12-.17(2) Quality Improvement

Such [written quality improvement] plan shall serve to continuously monitor the program's compliance with the requirements set forth in these rules. Responsibility for administering and coordinating the quality improvement plan must be delegated to a staff person who has been determined to be qualified by education, training, and experience to perform such tasks. The medical director shall be actively involved in the development of the plan and its full implementation.
Authority O.C.G.A. Sec. 26-5-2 et seq.

This Requirement is not met as evidenced by:

Based on review of the Quality Improvement (QI) plan and interview, it was determined that the facility failed to have a complete quality improvement plan that served as a continuous monitor of the program's compliance. The facility lacked documented evidence that the medical director was actively involved in the full implementation of the QI plan. The findings were:

A review of the Quality Improvement (QI) plan on 08/18/2011, revealed the QI plan #8 -(patient grievances) had no monthly documentation to show if the facility had issues in this area.. For QI plan #9 -(patient satisfaction) the facility collected surveys, but there is no documentation of the

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outcome of the surveys. QI plan #11- (medication issues) had no documentation of a discussion or follow-up regarding the issues that were address in the QI plan. The facility also lacked documented evidence that the medical director was actively involved in the development of the plan and its full implementation.

During an interview with the administrator on 08/18/2011 at 1:40 p.m., he/she confirmed the above findings.