Statement of Deficiencies and Plan of Correction	Inspection begin date 10/18/2012 Inspection end date: 10/18/2012
Name of Provider or Supplier TREATMENT CENTER OF VALDOSTA	Street Address, City, State Zip Code 2301 UNIVERSITY DRIVE SUITE C VALDOSTA, GA 31602

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E 0000 Opening Comments.

At the time of the survey, Treatment Center of Valdosta was not in compliance with Chapter 111-8-25, Enforcement of General Licensing and Enforcement Requirements, as a result of the investigation of complaint #GA00118535. The following violations were cited:

E 0401 111-8-25-.04(a) Enforcement

Enforcement. The department shall have the authority to impose any one or more of the sanctions enumerated in paragraphs (1), (2) and (3) of Rule 111-8-25-.05 upon a finding that an applicant or licensee has: (a) Knowingly made any verbal or written false statement of material fact either in connection with the application for a license; or on documents submitted to the department as part of any inspection or investigation; or in the falsification or alteration of facility records made or maintained by the facility;

This Requirement is not met as evidenced by:

Based on a review of Department of Community Health (DCH) records, employee records , and State of Georgia Composite Medical Board records, it was determined that the facility submitted documents for a Narcotic Treatment Program licensure application with false and misleading information.

Findings:

A review of the Department of Community Health (DCH) records revealed that the Principal Officer of the Governing Body of the facility (employee #8), represented himself as a State of Georgia Licensed Medical Doctor (M.D.), on a Narcotic Treatment Program licensure application dated February 27, 2006 and documents submitted to the Department to update the license dated June 26, 2006.

A review of employee #8's, employee record revealed, no documentation that he/she was licensed to practice medicine in the State of Georgia.

A review of the State of Georgia Composite Medical Board license verification system revealed

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that employee #8 was never issued a licensed to practice medicine.

A review of client records revealed no documentation that employee #8, provided medical care to clients at the facility.

E 0403 111-8-25-.04(c) Enforcement

The department shall have the authority to impose any one or more of the sanctions enumerated in paragraphs (1), (2) and (3) of Rule 111-8-25-.05 upon a finding that an applicant or licensee has: ...
(c) Failed to comply with the licensing requirements of this state;

This Requirement is not met as evidenced by:

Based on a review of state regulation, client records, and staff interview, it was determined that the facility failed to report to the Department an incident involving the death of one of three sampled discharged clients (clients #11).

Findings:

A review of facility's Discharge Summary By Reason form, from 2011 to 2012, revealed that client #11, was discharged from the facility on 3/8/12, and the reason for the discharge was documented as "deceased". There was no documented evidence that the client's death was reported to the Department.

An interview on 10/18/2012 at 10:00 a.m., with the clinical director, confirmed that client #11's death was not reported to the Department. The clinical director stated, "I have looked around, and cannot find documentation that the death was reported to the DCH".

A review of the Department records revealed that there was no documentation that the facility self reported the death of client #11.

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Z 0000 INITIAL COMMENTS

At the time of the survey, Treatment Center of Valdosta was not in compliance with Chapter 290-9-12, Rules and Regulations for Narcotic Treatment Programs, as a result of investigation #GA00118535. The allegations were substantiated. The following deficiencies were cited:

Z 0702 290-9-12-.07(3) APPLICATIONS

False or Misleading Information. An application for a license must be truthfully and fully completed. In the event that the Department has reason to believe that an application has not been completed truthfully, the Department may require additional verification of the facts alleged. The Department may revoke a license or refuse to issue a license where material false statements have been made on or in connection with an application.

This Requirement is not met as evidenced by:

Based on a review of Department of Community Health (DCH) records, employee records , and State of Georgia Composite Medical Board records, it was determined that the facility submitted documents for a Narcotic Treatment Program licensure application with false and misleading information.

Findings:

A review of the Department of Community Health (DCH) records revealed that the Principal Officer of the Governing Body of the facility (employee #8), represented himself as a State of Georgia Licensed Medical Doctor (M.D.), on a Narcotic Treatment Program licensure application dated February 27, 2006 and documents submitted to the Department to update the license dated June 26, 2006.

A review of employee #8's, employee record revealed, no documentation that he/she was licensed to practice medicine in the State of Georgia.

A review of the State of Georgia Composite Medical Board license verification system revealed that employee #8 was never issued a licensed to practice medicine.

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A review of client records revealed no documentation that employee #8, provided medical care to clients at the facility.

Z 1502 290-9-12-.15(a)2. NARCOTIC DRUGS

Individual doses shall be based on the clinical judgment of the program physician who has personally reviewed the patient's record and who has considered all available relevant information, including, but not limited to, drug screens, quantitative levels of methadone and related drugs, patient interview, and specific circumstances pertaining to the individual patient.

This Requirement is not met as evidenced by:

Based on a review of policy and procedure, client records, and staff interview, it was determined that the facility failed to ensure that the individual Methadone dosage for one of three sampled discharged clients (client #11), was based on the clinical judgment of the program's physician and was in compliance with the facility's protocol for initiating Methadone dosing.

Findings:

A review of the facility policy and procedure, Protocol for Initiating Methadone Dosing revealed that a patient with significant withdraw symptoms according to the Intake Withdraw Rating Scale (WRS) of >20 would start treatment on a 30 mg Methadone dose daily, and proceed to the 21 Day Titration Dose Protocol after examination by the physician. A patient with mild withdraw symptoms according the WRS <20, or if a patient requests a lower dose would start treatment on a 25 mg Methadone dose daily, and proceed to the 21 Day Titration Dose Protocol after examination by the physician.

A review of clients #11's discharge record revealed that the initial Methadone dose that the client received was not in compliance with the facility's dosing protocol. Client #11 scored a 13 (mild withdraw symptoms) on the WRS admission scale, and was administered an initial Methadone dose of 30 mg. No documentation was found on the Intake Medical Examination Record, or Physicians Progress Note that addressed why the patient was dosed outside of the facility's policy and procedure guidelines.

An interview with the clinical director on 10/18/2012 at 10:00 a.m., confirmed that the client was dosed outside of the policy and procedure guidelines. The clinical director stated, "There is no

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documentation in the record to justify why the client was dosed at 30 mg instead of 25 mg on admission, as per policy and procedure. "

Z 2000 290-9-12-.20(1) REPORTING TO THE DEPARTMENT

A narcotic treatment program shall report to the Office of Regulatory Services and also follow Division of MHDDAD reporting protocol whenever any of the following incidents involving patients occurs or the program has reasonable cause to believe that such an incident involving a patient has occurred:

(a) Any death of a patient;
(b) Any rape that occurs in the program;
(c) Any serious injury to a patient while at the program that requires medical attention;
(d) Any assault on a patient, any battery on a patient, or any abuse, neglect, or exploitation of a patient by program staff; and
(e) An external disaster or other emergency situation that affects the continued safe operation of the program.

This Requirement is not met as evidenced by:

Based on a review of state regulation, client records, and staff interview, it was determined that the facility failed to report to the Department an incident involving the death of one of three sampled discharged clients (clients #11).

Findings:

A review of facility's Discharge Summary By Reason form, from 2011 to 2012, revealed that client #11, was discharged from the facility on 3/8/12, and the reason for the discharge was documented as "deceased". There was no documented evidence that the client's death was reported to the Department.

An interview on 10/18/2012 at 10:00 a.m., with the clinical director, confirmed that client #11's death was not reported to the Department. The clinical director stated, "I have looked around, and cannot find documentation that the death was reported to the DCH".

A review of the Department records revealed that there was no documentation that the facility self reported the death of client #11.

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