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Z 0000 INITIAL COMMENTS

At the time of relicensure survey, it was determined that South Georgia Treatment Center was not in substantial compliance with the Rules and Regulations for Narcotics Treatment Programs, and the following deficiencies were cited.

Z 0911 290-9-12-.09(5)(g) ADMINISTRATION

Patient Records. ... Each patient record must contain, at a minimum, the following: ...

(g) Written consents, signed by the patient and dated and witnessed, as required in Rule 290-9-12-.12(1)(c)1.; ...

This Requirement is not met as evidenced by:

Based on review of client records and interviews, it was determined that the facility failed to ensure that each client signed consents of treatment, during the intake process for one of six clients (#4). The finding were:

A review of client records on 08/15/2011, revealed that one of six clients had no documentation

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that he/she signed a consent to treatment statement, before starting treatment at the facility.

During an interview on 08/15/2011 with the clinical director at 12:50 p.m., he/she confirmed the above findings.

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;
(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:

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

A review of employees' records on 08/15/2011 revealed the following:

1. Four of six employees (#1, #2, #5, and #6) did not have documentation that employees completed an orientation, prior to working with clients.

2. Four of six employees (#2, #3, #5, and #6) did not have documentation that the facility checked job references.

3. One of six employees (#4) did not have a signed job description.

4. One of six employees (#5) did not have 16 hours of annual training (13.75 hr. of training for 2010).

During an interview on 8/16/2011 with the clinical director at 12:45 p.m., 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

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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 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 a review of client records and staff interview, it was determined that the facility failed to consistently ensure that the clients were tested for infectious diseases for three of six sampled clients (#1, #2, and #3). The findings were:

A review of client records on 08/15/2011 revealed the following:

1. Three of six clients' (#1, #2, and #3) tuberculosis (TB) screenings were not done at the time of admission;

2). One of six clients (2) did not have documentation of a sexually transmitted disease (STD) screening.

During an interview on 08/15/2011 with the clinical director at 1:00 p.m., he/she confirmed the above findings.

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

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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
indicated, the program must ensure that such services are made available to the patient and appropriate referrals for additional care are made.

This Requirement is not met as evidenced by:

Based on review of medical records and interviews, it was determined that the facility failed to ensure that the individual treatment plans (ITP) were reviewed at least every 90 day during the first year of treatment for four of six sampled patients (#1, #2, #4, and #5). The findings were:

A review of client records on 08/16/2011, revealed that four of six clients' individual treatment plans (ITP) were not reviewed at least every 90 days during the first year of treatment.

During an interview on 08/16/2011 with the clinical director at 1:10 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:

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Based on review of client records and interview, it was determined that the facility failed to ensure that counseling was provided to patients in accordance to their identified needs and/or as specified in the clients' individualized treatment plans (ITP) for six of six sampled clients (client #1-#6). One of six sampled clients (#4), who was admitted for more than one year, did not have an ITP in the his/her record, to show that the client received any individual or group counseling.

In addition, the treatment plans failed to identify the duration and frequency of counseling sessions, based on clients' specific needs and the patients' phase in treatment, for six of six sampled clients (client #1-#6). The findings were:

A review of client records on 08/15/2011, revealed that counseling sessions, documented in the records for six of six clients, did not include the goals and objectives from the individualized treatment plans (ITP).

A review of client records also revealed, that one of six clients did not have documentation of an individualized treatment plan (ITP) being completed, or if the client was provided individual or group counseling appropriate to his or her needs.

A review of client records also revealed that six of six clients' ITPs did not include duration and frequency of counseling session based on the clients' needs. For example, the ITP included the following: Frequency: weekly or long/short (instead of the specific days that counseling will be offered to the client). Duration: blank (instead of the specific amount of time that counseling will be offered to the client).

During an interview with the clinical director on 8/15/2011 at 1:05 p.m., he/she confirmed the above findings.