STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY & HEALTH SYSTEMS

Shelly Edgerton
DIRECTOR

February 27, 2017

Narconon Freedom Center, SA0130110
Josh Sowers, Program Director
809 West Erie Street
Albion, MI 49224

SUBJECT: Substance Use Disorder Licensure Survey Findings for Narconon – Notice of Non-Compliance

Dear Mr. Sowers:

An annual state licensure inspection was conducted on February 27, 2017 at Narconon Freedom Center pursuant to Michigan Public Health Code, Act 368 of 1978, Part 62, Section 333.6238, which obligates the department to make at least one visit to each licensed health facility or agency every three years for survey and evaluation for the purpose of licensure.

Based on the state licensure inspection findings, the Department has determined that Narconon Freedom Center is not in substantial compliance with the following requirements:

R325.14302(6)(e) Recipient Rights Brochure

A form approved by the office which indicates that the recipient understands the rights and consents to specific restrictions of rights based on program policy. The recipient shall sign this form. One copy of the form shall be provided to the client and 1 copy shall become a part of the client's record.

R325.14302(7) Progress Notes

A recipient of prevention services shall be notified of his or her rights by a notation on any program announcement, brochure, or other written communication that describes the program services to recipients or to the general public. Such notification shall state the following: "Recipients of substance abuse services have rights protected by state and federal law and promulgated rules.

R325.14302(9) Recipient Rights Poster

Rights of recipients shall be displayed on a poster provided by the office in a public area of all licensed programs. The poster shall indicate the program rights advisor's name and phone number.

R325.14701(5) Records and Documentation

There shall be an assessment of each client's social and psychological needs. The areas of concern shall include a determination of the following: current emotional state, cultural background, vocational history, family relationships, educational background, socioeconomic status, and any legal problems that may affect the treatment plan.

R325.14707 Outpatient Progress Notes

A client's progress and current status in meeting the objectives established in the treatment plan, together with a statement of the efforts by staff members to help the client achieve these stated objectives, shall be recorded in the client's case record for every formal client counseling session. A progress note shall be dated and signed by the individual who makes the entry.

R325.14708 Discharge Summary

Within 2 weeks after discharge, the counselor shall enter in the client's case record a discharge summary describing the rationale for discharge, the client's treatment and rehabilitation status or condition at discharge, and the instructions given to the client about aftercare and follow-up.

R325.14901(2) Counselor

The equivalent of 1 full-time counselor shall be available for every 10 residents.

R325.14902 Admission Record

(1) Clearly stated written criteria for determining the eligibility of individuals for admission shall be developed by the residential program.

(2) Information gathered in the course of the admission and assessment process shall be recorded on internally standardized forms. The completed forms shall become part of the applicant's case record.

(3) The program shall have written policies and procedures governing the admission process which set forth both of the following: (a) The procedures to be followed when accepting referrals from outside agencies or organizations, (b) The procedures to be followed, including those for referrals, when an applicant is found to be ineligible for admission.

(4) All of the following information shall be collected and recorded for all applicants before, or at the time of, admission: (a) Name, address, and telephone number, when applicable, (b) Date of birth and sex, (c) Family and social history, (d) Educational history, (e) Occupation, (f) Legal and court-related history, (g) Present substance abuse problem, (h) Date the information was gathered, (i) Signature of the staff member gathering the information, (j) Name of referring agency, when appropriate, (k) Address, telephone number, and name of nearest relative to contact in case of emergency, (l) History of current and past substance abuse or other counseling services received, the agency, type of service, and the date the service was received shall be indicated, (m) Name, address, and telephone number of the most recent family or private physician, (n) A substance abuse history, including information about prescribed drugs and alcohol, which indicates, at a minimum, all of the following information, (i) Substances used in the past, including prescribed drugs, (ii) Substances used recently, especially those used within the last 48 hours, (iii) Substances of preference, (iv) Frequency with which each substance is used, (v) Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions, (vi) History of previous substance abuse treatment received, (vii) Year of first use of each substance.

R325.14905 Treatment Plan

(1) A client's social and psychological needs shall be assessed. The areas of concern shall include a determination of all of the following: (a) Current emotional state, (b) Cultural background, (c) Vocational history, (d) Family relationships, (e) Educational background, (f) Socioeconomic status, (g) Any legal problems that may affect the treatment plan.

(2) A written treatment plan based upon the assessment made of a client's needs shall be developed and recorded in the client's case record. A treatment plan shall be developed as soon after the client's admission as feasible, but before the client is engaged in extensive therapeutic activities. The written treatment plan shall comply with all of the following: (a) Be individualized based upon the assessment of the client's needs and, if applicable, the medical evaluation, (b) Specify those services planned for meeting the client's needs, (c) Include referrals for services that are not provided by the residential program, (d) Contain clear and concise statements of the objectives the client will be attempting, to achieve, together with a realistic time schedule for their achievement, (e) Define the services to be provided to the client, the therapeutic activities in which the client is expected to participate, and the sequence in which services will be provided.

(3) The client shall participate in the development of the treatment plan and its objectives. The nature of this participation shall be described in the client's record.

(4) Review of, and changes in, the treatment plan shall be recorded in the client's case record. The date of the review or change, together with the names of the individuals involved in the review, shall also be recorded. The treatment plan shall be reviewed at least once every 90 days by the program director or his or her designee.

R325.14906 Patient Activities

Ten or more hours per week of scheduled activities shall be available to a client. Included in these activities shall be 2 or more hours of formalized individual, group, or family counseling for each client. The hours of counseling actually provided should vary according to the needs of the client. There shall be documentation of planned social, educational, and recreational activities consistent with the needs of the client. Activities shall include all clients and shall take place days, evenings, and weekends if clients are present during these times.

R325.14907 Residential Progress Notes

A client's progress and current status in meeting the objectives established in the treatment plan, together with a statement of the efforts by staff members to help the client achieve these stated objectives, shall be recorded in the client's case record for every formal client counseling session. A progress note shall be dated and signed by the individual who makes the entry.

(2) All progress notes shall be dated and signed by the individual who makes the entry.

(3) If a client is receiving services at an outside resource, the program shall attempt to secure a written case summary, case evaluation, and other client records from that resource. These records shall be added to the client's case record.

(4) The ongoing assessment of the client's progress with respect to achieving treatment plan objectives shall be used to update the treatment plan.

R325.14908 Support and Rehabilitative Services

(1) All of the following support and rehabilitation services shall be available to all clients either internally or through the referral process: (a) Education, (b) Vocational, counseling and training, (c) Job development and placement, (d) Financial counseling, (e) Legal counseling, (f) Spiritual counseling, (g) Nutritional education and counseling,

(2) A program shall maintain a current listing of services available on-site and by referral. This listing shall be reviewed with each client as part of the program's orientation procedure.

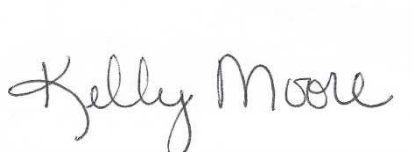
R325.14909 Discharge Summary

Within 2 weeks after discharge, there shall be entered in the client's case record a discharge summary describing the rationale for discharge, the client's treatment and

rehabilitation status or condition at discharge, and the instructions given to the client about aftercare and follow-up.

Additionally, after speaking with the program director, the program advised that they are no longer administering residential detoxification treatment at their facility. Therefore, failure to no longer provide this service has resulted in removal of residential detox from their license as of February 27, 2017.

Based upon the above noted deficiencies at the time of the site visit, the program shall be required to submit a written plan of corrections. This plan must be submitted to state licensing within 15 days and a follow up survey will be conducted in 30 days to determine overall compliance.



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