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	MGL046-039	A. BUILDING: _____ B. WING _____	03/21/2022

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JK2C, LLC DBA AHOSKIE TREATMENT CENTE	312 SOUTH ACADEMY STREET, SUITE D AHOSKIE, NC 27910

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 3/21/22. The complaint was substantiated (intake #NC 00185596). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility has a current census of 83. The survey sample consisted of audits of 9 current clients, and 1 deceased client. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	Point of contact for this SOD is Charla Huff, Program Director at Ahoskie Treatment Center. Charla Huff	5/15/22
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records.	V 105	Plan of Correction: Program Director will ensure that a Nurse Practioner will complete onboarding and provide supervision to all nurses. Program Direcotr will ensure that the current RN will remain on call for all nurses. Program Director will monitor all nursing supervision through weekly observation. The facility will meet all requirments for 10A NCAC 27.6.0201 no later than 5/20/22. Since this citation was made, a Nurse Practioner, Brittany Howell was hired who is onsite weekly and on call daily. Brittany supervises all nurses at Ahoskie Treatment Center. Additionally, Carrie Yost is on-call for nurses as a leading support. Program Director will ensure efficient communication and weekly meetings occur between Nurse Practitioner and Nurses onsite.	

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V 105	Continued From page 1 (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		5/15/22

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement and develop standards that ensured operational and programmatic performance meeting applicable standards of practice for the assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse (RN). The findings are:

Record review on 3/21/22 of LPN #1's personnel record revealed:
- Hire date 9/20/21

Interview on 3/16/22 the Licensed Practial Nurse (LPN) #1 reported:
- She was hired in September of 2021.
- She was supervised by LPN #3A.
- LPN #3A came to the facility once or twice a week.
- The RN was located at the Sister Facility A.
- The RN had never been to the facility.
- She had never talked to the RN, or met her for supervision.

Interview on 3/16/22 the LPN #3A reported:
- She was hired by the Sister Facility A in 2020.
- She worked in the Sister Facility A location and had been promoted to a nurse manager position of the facility LPN staff.
- She came to the facility once a week, sometimes twice a week to supervise staff.

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V 105	Continued From page 3 Interview on 3/21/22 the Program Director reported: - There were 2 LPN staff at the facility on a regular basis. - LPN #3A was from the Sister Facility A and had been promoted three weeks ago to a supervisor position. - LPN #3A currently supervised all the LPN's at the facility. - LPN #3A is an LPN. - LPN #3A is on site at the facility one day per week. - The previous facility RN left the employment with the facility in September 2021. - LPN #3A contacted the Sister Facility A RN via phone when she needed assistance. - The RN from the Sister Facility A had not visited the facility for supervision with the LPN's. - The Medical Director did not supervise the nursing staff. - He was in contact with them, but was not their direct supervisor. - She was in the process of hiring a Family Nurse Practitioner that would be on site on 3/28/22 and would supervise the LPN staff.	V 105		5/15/22
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the	V 235	Plan of Correction: Program Director will hire two new Licensed counselors to attend facility onsite so that two counselors are available at all times and carry the required case load of less than 50 patients. Program Director will ensure that caseloads meet criteria by striving to retain counseling staff and monitoring caseloads through daily supervision. Requirements of 10 NCAC 27G.3603 will meet compliance as of 5/15/22.	

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V 235	Continued From page 4 certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor was on staff of the facility for each 50 clients and increment thereof. The findings are: Review on 3/16/22 of the facility records revealed: - Patient census report indicated a total of 83 clients received treatment at the facility. Review on 3/16/22 of the Client Census form and interview with the Program Director revealed: - One counselor on staff for the facility and the Program Director carrying counseling caseloads. Interview on 3/16/22 with clients #1002, #1063,	V 235	Since the site visit, two Licensed Clinical Addiction Specialists, Jerry Roth, LCAS-A and Joseph Hodgson, LCAS have been added onsite to ATC. Additionally, Jimmy Vaughan, CADC-R, is onsite two days weekly. All caseloads are below 50 patients. Program Director will continue to monitor caseloads to ensure patients are seen bi-monthly or as appropiate.	5/15/22

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V 235	Continued From page 5 #1035, and #1019 reported: - They had never had counseling with the Program Director. Interview on 3/16/22 the Counselor reported: - He left the facility on 12/16/21. - His re-hire date was 2/23/22. - He had seen all the current clients in the facility while the Program Director was onboarding. Interview on 3/16/22 the Medical Director reported: - He had been the Medical Director of the facility since 2019. - They have had a lot of turnover and it had been problematic in terms of counselors. - They had gone over 50 clients per counselor a couple of times since he had been the Medical Director. - The facility had difficulty with staff turnover. Interview between 3/16/22 and 3/21/22 the Program Director reported: - She was hired by the Sister Facility A as the Program Director 10/22/21. - The previous Program Director of the facility was terminated on February 20, 2022. - She was hired as the Program Director for the facility on February 20, 2022. - The Previous Program director was the only counselor at the facility from 12/16/21-2/20/22. - The Counselor was re-hired on 2/23/22. - The Counselor carried a current caseload of 48 clients. - As the Program Director, she was carrying a caseload of 36 current clients at the facility. - She was at the facility one day a week. - She had not seen any of her clients yet as she had just been promoted to the role on	V 235		

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V 235	Continued From page 6 2/20/22. - The Counselor had been seeing all clients from 2/23/22-3/21/22 while she was onboarding. - She was in the process of hiring two new counselors.	V 235		5/15/22
V 238	27G .3604 (E-K) Outpt. Opiod - Operations 10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program approval on the following criteria: (1) compliance with all state and federal law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month. (1) Levels of Eligibility are subject to the following conditions:	V 238	Plan of Correction: Re-train all staff on completing all aspects of central registry to include enrollment of Central Registry, dual enrollment checks and discharge. Program Director will ensure and monitor current and incoming staff and assign training on Central Registry to meet compliance with state and federal regulations as outlined in 10A-NCAC 27G.3604. While trainings will continue to be ongoing, current compliance is met on 5/15/22. Since the site visit, all patients are enrolled in Central Registry and discharged from Central Registry when discharged from the facility. A dual enrollment check is ensuringly performed prior to admission. A copy of the dual enrollment form is included in all patient's charts. Program Director will continue to monitor staff for compliance in accordance of 10A-NCAC 27G.3604.	

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V 238	Continued From page 7 (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic; (B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week; (C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week; (D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week; (E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week; (F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and (G) Level 7. After four years of continuous treatment and a minimum of three years of continuous program compliance, a client may be granted for a maximum of 30 take-home doses	V 238		5/15/22

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V 238	Continued From page 8	V 238		5/15/22

and shall ingest at least one dose under supervision at the clinic every month.
(2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility:
(A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility;
(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and
(C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program.
(3) Exceptions to Take-Home Eligibility:
(A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment.
(B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall make monthly clinic visits.
(4) Take-Home Dosages For Holidays:

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V 238	Continued From page 9 Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following: (A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday. (B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above. (g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter. (h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. (i) Client Discharge Restrictions. No client shall be discharged from the facility while physically	V 238		

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V 238	Continued From page 10 dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug. (j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina State Authority for Opioid Treatment. (k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements: (1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges; (2) call-in's for bottle checks, bottle returns or solid dosage form call-in's; (3) call-in's for drug testing; (4) drug testing results that include a review of the levels of methadone or other medications approved for the treatment of opioid addiction;	V 238		

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V 238	Continued From page 11 (5) client attendance minimums; and (6) procedures to ensure that clients properly ingest medication. This Rule is not met as evidenced by: Based on record review and interview the facility failed to follow their dual enrollment policy for 4 of 10 audited clients (#1019, #1063, #1039 & #1077). The findings are: Review on 3/21/22 of the facility's enrollment policy revealed: "...all clients will have a central registry check done on them prior to admission..." Review on 3/16/22 of client #1019's record revealed: - admitted 2/21/20 - diagnosis of Opioid Dependence - central registry completed 2/25/20 Review on 3/16/22 of client #1063's record revealed: - admitted 7/4/20 - diagnosis of Opioid Dependence - central registry completed 7/29/20 Review on 3/21/22 of client #1039's record revealed: - admitted 10/30/21 - diagnosis of Opioid Dependence - central registry completed 11/2/21	V 238		

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V 238	Continued From page 12 Review on 3/21/22 of client #1077's record revealed: - admitted 10/30/21 - diagnosis of Opioid Dependence - central registry completed 11/2/21 During interview on 3/16/22 Licensed Practical Nurse (LPN) reported: - started September 2021 - the prior LPN informed her to complete the central registry checks upon the clients' first dose of methadone During interview on 3/21/22 the Program Director reported: - started on 2/20/22 - had tried to address all deficits since she started at the facility - she was currently addressing central registry checks - the nurses completed the central registry checks - central registry checks should be completed on the day of admission to the facility	V 238	P	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367	Plan of Action: Current Program Director will ensure that any Incident Report is documented accordingly to include Level 2 Incident Reports include submission to IRIS which includes appropriate data. Facility will meet compliance of 10A NCAC 27G.0604 on 5/15/22. Since the site visit, the current Program Director has been re-trained on incident reporting. No Level 2 incident reports have occurred at this facility since the site visit.Program Director will continue to monitor daily operations that require incident reporting as outlined in 10 A NCAC 27G.0604.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MGL046-039	A. BUILDING: _____ B. WING _____	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JK2C, LLC DBA AHOSKIE TREATMENT CENTE	312 SOUTH ACADEMY STREET, SUITE D AHOSKIE, NC 27910

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V 367	Continued From page 13	V 367		

becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

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V 367	Continued From page 14 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Level III incident report was completed & submitted to the LME/MCO (Local	V 367		

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V 367	Continued From page 15 Management Entity/Managed Care Organization) within 72 hours for 1 of 1 deceased client (DC#1009). The findings are: Review on 3/16/22 of an incident report for DC #1009 revealed: - dated 11/17/21 - "...around 5:10am the medical staff informed Program Director (PD) that patient 1009 had passed away...was discovered unresponsive in his car on 11/17/21...patient's last dose was 11/15/21..." During interview on 3/21/22 the PD reported: - started at the facility on 2/20/22 - the previous PD was responsible for submitting the Level III incident report - had an incident response improvement system (IRIS) number for DC #1009 dated 11/17/21, however, some of the pages of the incident report was incomplete - she would ensure Level II & III incident reports were submitted to the LME/MCO in the future	V 367		