TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-166		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			R 01/2025
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE		
	291 HUE		,		
	JACKSC	NVILLE, NC 2	28546		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
INITIAL COMMEN	TS	V 000			
completed on May unsubstantiated (in	1, 2025. The complaint was take #NC00228652). A				
categories: 10A NC Opioid Treatment a	CAC 27G .3600 Outpatient and 10A NCAC 27G .4400				
.3600 Outpatient O census of 434 and Intensive Outpatier current census of 0 consisted of audits	pioid Treatment has a current the .4400 Substance Abuse at Program (SAIOP) has a b. The survey sample of 20 current clients and 2				
27G .3604 (A-D) O	utpt. Opioid - Operations	V 237			
(a) Hours. Each fa days per week, 12 weekend and holid	acility shall operate at least six months per year. Daily, ay medication dispensing				
Mental Health Serv or The Center for S (CSAT) Regulation certified by a privat agency, that has be	vices Administration (SAMHSA Substance Abuse Treatment s. Each facility shall be e non-profit entity or a State een approved by the SAMHSA				
Human Services an all SAMHSA Opioic Detoxification Trea	nd shall be in compliance with I Drugs in Maintenance and tment of Opioid Addiction				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L INITIAL COMMENT An annual, compla completed on May unsubstantiated (in deficiency was cite This facility is licent categories: 10A NC Opioid Treatment a Substance Abuse I (SAIOP). This facility has a c .3600 Outpatient O census of 434 and Intensive Outpatier current census of O consisted of audits former clients in the 27G .3604 (A-D) O 10A NCAC 27G .36 (a) Hours. Each fa days per week, 12 weekend and holid hours shall be sche the client. (b) Compliance wi Mental Health Serv or The Center for S (CSAT) Regulation certified by a privat agency, that has be of the United State Human Services an all SAMHSA Opioid Detoxification Trea	MHL067-166 PROVIDER OR SUPPLIER STREET A PNVILLE TREATMENT CENTER, LLC 291 HUF JACKSC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual, complaint and follow up survey was completed on May 1, 2025. The complaint was unsubstantiated (intake #NC00228652). A deficiency was cited. A deficiency was cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP). This facility has a current census of 434. The .3600 Outpatient Opioid Treatment has a current census of 434 and the .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 0. The survey sample consisted of audits of 20 current clients and 2 former clients in the Outpatient Opioid Treatment 27G .3604 (A-D) Outpt. Opioid - Operations 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday medication dispensing hours shall be scheduled to meet the needs of the client. (b) Compliance with The Substance Abuse and Mental Health Services Administration (SAMHSA or The Center for Substance Abuse Treatment (CSAT) Regulations. Each facility shall be certified by a private non-profit entity or a State agency, that has been approved by the SAMHSA of the United State Department of Health and	MHL067-166 B. WING	MHL067-166 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NVILLE TREATMENT CENTER, LLC 291 HUFF DRIVE JACKSONVILLE, NC 28546 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSCIDENTIFYING INFORMATION) Image: Design of the precession the precession of the	MHL067-166 B. WING 05/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 291 HUFF DRVE JACKSOWULE, NO 28546 291 HUFF DRVE JACKSOWULE, NO 28546 NVILLE TREATMENT CENTER, LLC 291 HUFF DRVE JACKSOWULE, NO 28546 PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MIST DE PRECEDED BY DLL REGULATORY OR LSC IDENTIFYING INFORMATION) IN PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY DLL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS V 000 V 000 PREFIX TAG V 000 INITIAL COMMENTS V 000 V 000 PREFIX TAG PREFIX TAG PREFIX TAG An annual, complaint and follow up survey was completed on May 1, 2025. The complaint was unsubstantiated (intake #NC00228652). A deficiency was cited. V 000 INITIAL COMMENTS JS00 OULpatient Opioid Treatment has a current census of 0.34 and the .4400 Substance Abuse intensive Outpatient Opioid Treatment has a current census of 0.34 and the .4400 Substance Abuse corrections in the Outpatient Opioid Treatment census of 0.01, Opioid - Operations V 237 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday metication dispensing hours shall be scheduled to meet the needs of the client. V 237

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		СОМ (°СОМ	E SURVEY PLETED
		MHL067-166	B. WING			01/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
JACKSC	ONVILLE TREATMENT	CENTER, LLC 291 HUF	F DRIVE NVILLE, NC 2	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
V 237	Continued From pa	age 1	V 237			
	available from the 0 5600 Fishers Lane, no cost. (c) Compliance Wi facility shall be curr Federal Drug Enfor shall be in complian Administration regu- treatment programs and Drugs, Part 13 incorporated by refu- amendments and e available from the 0 Printing Office, Was published rate. (d) Compliance W Each facility shall b Carolina State Auth DMH/DD/SAS, whi the Secretary of He exercise the respon- state for governing an opioid drug, incl monitoring complia related to scope, st monitoring complia 102-321. The refer obtained from the S Section of DMH/DD This Rule is not me Based on record ref failed to ensure clie counseling session year of treatment a session in all subsec current clients audi	editions. These regulations are CSAT, SAMHSA, Rockwall II, , Rockville, Maryland 20857 at ith DEA Regulations. Each rently registered with the reement Administration and nce with all Drug Enforcement alations pertaining to opioid s codified in 21 C.F.R., Food 00 to end, which are erence to include subsequent editions. These regulations are United States Government shington, D.C. 20402 at the ith State Authority Regulations. The person designated by eath and Human Services to nsibility and authority within the the treatment of addiction with uding program approval, for nce with the regulations faff, and operations, and for nce with Section 1923 of P.L. renced material may be Substance Abuse Services D/SAS. et as evidenced by: eview and interview, the facility ents attended a minimum of 2 us per month during the first nd at least 1 counseling equent years, affecting 8 of 20 ted (#2105, #2138, #2491, 40, #3106 and #3109). The				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	СОМ	E SURVEY PLETED
		MHL067-166	B. WING			R 01/2025
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ACKSO	NVILLE TREATMENT	CENTER, LLC 291 HUF	F DRIVE	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 237	Continued From pa	age 2	V 237			
	revealed: -Admission date of -Diagnoses of opio -Order dated 04/21 methadone by 5 mi for COWS (Clinical over 5 to max dose -Current methadon Review on 04/30/22 notes revealed: -No documentation 2 counseling sessio November 2024, D 2025. Interview on 04/30/ -He had been received for 8 months. -He saw his counse Finding #2: Review on 04/30/25 record revealed: -Admitted 06/27/23 -Diagnoses of opio -Order dated 10/08 request for a volum was 73 mg of meth by 2 mg every two Client #2105 could felt uncomfortable.	id use disorder, severe. /25, client may increase illigrams (mg) every other day Opiate Withdrawal Scale) e of 100 mg of methadone. e dose was 40 mg. 5 of client #3106's counselor that client #3106 was seen for ons for the months of ecember 2024 and February 25 client #3106 stated: iving treatment at the facility elor once per week. 5 - 05/01/25 of client #2105's duse disorder, severe. /24 approved client #2105's tary taper. His current dose adone and he could decrease weeks until he reached 40 mg. stop his taper at any time if he				
	was at 73 mg of me	continued his taper down and ethadone on 05/01/25. 5 - 05/01/25 of client #2105's vealed:				

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STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
	MHL067-166		B. WING		R 05/01/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
JACKSO	NVILLE TREATMENT	CENTER LLC	F DRIVE	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 237	Continued From pa	age 3	V 237			
	seen for counseling July 2024, August 2	umentation client #2105 was g sessions for the months of 2024, September 2024, anuary 2025, and February				
	-He had been gettir approximately 5 ye -He was uncertain as he had recently	25 client #2105 stated: ng treatment at the facility for ars. who his current counselor was changed counselors. elor once per month.	i,			
	revealed: -Admitted 11/25/22 -Diagnoses of opio -Order dated 02/21 methadone by 5 mg over 5, up to max c	id use disorder, severe. /25, client may increase g every other day for COWS lose of 80 mg of methadone. e dose was 77 mg of				
	notes revealed: -There was no doc seen for counseling	5 of client #2138's counselor umentation client #2138 was g sessions for the months of 24, August 2024, and				
		25 client #2138 stated: mber the name of his elor twice a month.				
vision of H	Finding #4: Review on 05/01/2 revealed: -Admitted 03/16/21 ealth Service Regulation	5 of client #2491's record				

Division of Health Service Regulation STATE FORM

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If continuation sheet 4 of 8

	of Health Service Re	eguiation (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL067-166	B. WING			R 01/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		291 HUF				
JACKSO	NVILLE TREATMENT	CENTER LLC	NVILLE, NC 2	8546		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID			(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
V 237	Continued From pa	age 4	V 237			
		id use disorder, severe.				
		/25 approved client #2491's				
		tary taper. Her current dose				
		adone and she could weekly until she reached 40				
		ould stop her taper at any time				
	if she felt uncomfor					
		continued her taper down and				
	was at 40 mg of methadone on 05/01/25.					
	Review on 05/01/25 of client #2491's counselor					
	notes revealed:					
	-There was no doc	umentation client #2491 was				
	seen for counseling May 2024 - Octobe	g sessions for the months of r 2024.				
	Interview on 04/30/	25 client #2491 stated:				
		eiving treatment for 5 years.				
		selor at least every month, and	1			
	more often as need	1ed.				
	Finding #5:					
		of client #3040's record				
	revealed:	00/40/04				
	-Admission date of					
		bid Use Disorder, severe. /25, Decrease dose to				
		today and daily. Continue				
	0	2 mg every 2 weeks starting				
		າold taper at methadone 30 mູ	3			
	daily.					
	-	stop taper at any time he is				
	uncomfortable. -Current methadon	e dose was 40mg.				
		of client #3040's counselor				
	notes revealed:					
	-There was no doc	umentation client #3040 was				
		eling session for the months o	f			
	January 2025 and I	February 2025.				

Division of Health Service Regulation STATE FORM

If continuation sheet 5 of 8

	of Health Service Re	egulation (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		PLETED
		MHL067-166	B. WING		R 01/2025
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		
		291 HUFI			
JACKSO	NVILLE TREATMENT	CENTED IIC	NVILLE, NC 2	28546	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	DATE
V 237	Continued From pa	ige 5	V 237		
	-He had been gettir year. -The Program Direc	25 client #3040 stated: ng treatment at the facility for a ctor was his counselor. elor twice a month to discuss cerns.			
	revealed: -Admission date of -Diagnoses of Opic -Order dated 11/21, methadone 85 mg by 5 mg every othe dose methadone 10 Kit with Educations	vid Use Disorder, severe. /24, Increase dose to today and daily, may increase r day for COWS over 5 max 00 mg daily. Provide Narcan			
	notes revealed: -There was no doci	of client #2949 counselor umentation client #2949 was eling sessions for the month of			
	revealed: -Admission date of -Diagnosis of Opioi -11/20/24 Increase 5mg to maximum of COWS over 5.	d Use Disorder, Severe. to dose 85 mg and increase			
vision of H	notes revealed:	of client #2955's counselor e for the month of February			

Division of Health Service Regulation STATE FORM

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If continuation sheet 6 of 8

STATEMEN	of Health Service Realth Service Realth Service Realth Service Realth of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		MHL067-166	067-166 B. WING			R 01/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
IACKSO	NVILLE TREATMENT		F DRIVE	28546			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
V 237	Continued From pa	age 6	V 237				
	-She had received -The Program Dire	25 client #2955 stated: services for 8 months. ctor was her counselor. selor twice a month and as					
	revealed: -Admission date of -Diagnosis of Opioi -02/7/25 - Stop tape	d Use Disorder, Severe. er current dose at 78 mg. Omg with COWS score of 5.					
	notes revealed:	5 of client #3109's counselor s documented for March 2025	5.				
	-He had received s -Counselor #1 was -He met with couns	elor #1 monthly. f the number of times he met					
	-She worked at the -Clients in treatmer required to be seen month. -Clients in treatmer were required to be time a month.	25 Counselor #1 stated: facility for 2 years. In tor less than one year were to by a counselor twice a to for greater than one year e seen by the counselor one to be seen as needed for					
		25 Counselor #2 stated: facility since 09/23/24.					

STATE FORM

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If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA).		(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL067-166	B. WING			R 01/2025
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ACKSO	NVILLE TREATMENT	CENTER LLC	F DRIVE			
		JACKSC	NVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 237	Continued From pa	age 7	V 237			
	required to be seen month. -Clients in treatmen were required to be time a month. Interview on 04/30/ -She had worked a 2025. -Clients in treatmen required to be seen month. -Clients in treatmen were required to be time a month. During interview on Director revealed: -She noticed the tre system during the f -She felt the couns sessions and had r that had been com	nt for less than one year were n by a counselor twice a nt for greater than one year e seen by the counselor one /25 Counselor #3 stated: it the facility since February nt for less than one year were n by a counselor twice a nt for greater than one year e seen by the counselor one n 05/01/25 the Program end of not having notes in the holiday months. selors had completed the not documented the sessions pleted with the patients. ad been provided education 'if it was not documented then				

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If continuation sheet 8 of 8