STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL074-275	A. BUILDING: _____ B. WING _____	01/30/2026

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GREENVILLE TREATMENT CENTER	2070 WEST ARLINGTON BOULEVARD GREENVILLE, NC 27834

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on January 30, 2026. The compliant was unsubstantiated (intake #NC00235115). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility has a current census of 297. The survey sample consisted of audits of 15 current clients and 1 deceased client.	V 000		
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 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	V 367		

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V 367	Continued From page 1	V 367		

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 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

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V 367	Continued From page 2 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 notify the Local Management Entity/Managed Care Organization (LME/MCO) of a level II incident as required. The findings are: Review on 01/28/26 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II incident report had been submitted for client #369's medication error on 1/20/26. Review on 1/28/26 of client #369's record revealed: -Admission date of 11/13/24. -Diagnoses of Severe Opioid Disorder. -Current daily dose of methadone 45 milligrams	V 367		

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V 367	Continued From page 3 (mg). Review on 1/28/26 of a facility incident report dated 1/20/26 revealed: -"Narrative Description! Of Incident (Be Factual, Objective and Concise: Write or Print) On 20 January 2026 at about 0644hrs (6:44am) (hours) patient 0369 (client #369) was administered 100mgs of methadone more than her prescribed dose..." -Nursing staff immediately requested client #369 remain in the clinic. -Facility physician was notified and advised that client #369 go to Emergency Department. -Client #369 refused to seek immediate care and signed Against Medical Advice (AMA) for refusal of additional care. -Program Director and Licensed Practical Nurse (LPN) #2 advised client #369 of the signs and symptoms of overdose. Review on 1/28/26 of physician's notes for client #369 dated 1/20/26 revealed: -He received a call from nursing staff around 6:30am client #369 had received the wrong medication dosage. -Client #369 had been given another client's methadone dosage. -"It could be very dangerous. Asked to send patient to ED (Emergency Department) immediately even she (client #369) felt OK now. I personally called [Clinical Director Name], clinical director and [Regional Director Name] regional director to confirm this order if she was 'ok' due to possible delay reaction such as respiratory failure or cardiac conduction programs Qtc (Electrocardiogram) prolongation which could cause severe arrhythmia." Review on 1/28/26 of the Program Director Notes	V 367		

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V 367	Continued From page 4 dated 1/20/26 revealed: -"On 20 January 2026 at about 0644hrs patient 0369 (client #369) was administered 100mgs of methadone more than her prescribed dose." -Nursing staff immediately requested client #369 remain in the clinic. -The physician was notified and advised that client #369 go to Emergency Department. -Client #369 did not want to go to hospital and had to report to work. -The clinic staff would be doing hourly wellness checks. -Provided several doses of Naloxone. Interview on 1/28/26 client #369 stated: -She recalled the medication error on 1/20/26. -The clinic was busy and she received the wrong methadone dosage. -She was advised to go to the ED. -She initially refused to go to the ED. -Clinic staff provided observation at her work site. -She decided to go to the ED and was kept overnight at the hospital. -She had episodes of vomiting and felt sleepy. -She had never had issues with medication errors in the past. Interview on 1/28/26 LPN #2 stated: - She recalled the incident with client #369 regarding the medication error. -Client #369 received the wrong dosage of methadone. -She realized the mistake and contacted the physician. -The facility doctor requested client #369 to go to the hospital. -Facility staff educated client #369 on the dangers of methadone overdose. -Client #369 initially refused to go to the hospital. -Client #369 eventually went to the hospital on	V 367		

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V 367	Continued From page 5 1/20/26. -She contacted the ED physician and nurse supervisor regarding client #369's medication error. Interview on 1/29/26 and 1/30/26 the Regional Director stated: -She or the Program Director would complete IRIS reports. -An IRIS report was not completed because client #369 did not have severe side effects from the methadone medication error on 1/20/26. -Client #369 was advised to go to the ED for a precaution. -The facility had subsequently completed a Level II IRIS report regarding the 1/20/26 medication error with client #369.	V 367		