# DCH/ HFR site visit results

YEAR 2024

#### State of GA, Healthcare Facility Regulation Division

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:	ISTRUCTION	(X3) DATE SURVEY COMPLETED:
	NTP001061	DOILDING.		12/17/2024
IAME OF PROVIDER OR SUPPLIER	l	STREET ADDRESS, O	CITY, STATE, ZIP CODE	
IEW START TREATMENT, LLC		600 SOUTH 8TH S GRIFFIN GA 30224		
verified records for shall include: (a) Ide current address, cur emergency contact history or a comple has not worked five check obtained fror agency that reflects convictions of a crir 111-8-5303, within working in an admi providing care to peer counselors, the record check which crime such as those Records of education of employment; (f) statements of the pocumentation of these rules; 111-8-5 employee's perform status of the employment is curr.  This RULE is not mean that Staff F of documentation of the following:  A review	A program shall maintain written and each employee. Each employee fila entifying information including name, reent telephone number, and persons; (b) A five-year employment te employment history if the person vyears; (c) Evidence of a criminal record in a state or local law enforcement the individual does not have any me, as defined in paragraph (f) of Rule in the previous five years; for employees nistrative capacity who are not attents and for employees working as a program may accept a criminal includes conviction of a nonviolent to listed in 111-8-5303(f)(12)-(17); (d) anal qualifications if applicable; (e) Date The person's job description or erson's duties and responsibilities; (g) training and orientation required by say (h) Any records relevant to the nance, including an appropriate health yie; and (i) Evidence that any required as a condition of ent and in good standing.  The staff records revealed information:  The staff records revealed information:  The staff records revealed and G did not have on of a five-year history on file.  The staff records revealed and G did not have on of an annual job evaluation on file.  The staff records revealed and G did not have on of an annual job evaluation on file.		To address the Administ deficiencies identifications will be implementations will be implementations will be implementations.  Staff F's employment he obtained and added personnel file by Janus Staff D and G will under job performance evaluated documentation added to personnel files by February Staff Trained for Staff G at their personnel file has 1, 2025.  2. Staff Training:  All supervisory staff trained on proper documentation on proper documentation on proper documentation on proper documentation of personnel records.  3. Monitoring:  HR representative will monthly audit of person discussed during quart assurance meetings.  4. Responsible Party:  The Program Sponsor/ Oresponsible for monitoring personnel for	ed in the corrective mented: dent distory will to their vary 1, 2025. dergo annual ations, with or their coruary 15, ent will be and added to be be mentation complete dent conduct a connel records with results erly quality defined the coring the coring the corporation.

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 1/15/25

STATE FORM If continuation sheet 2 of 4

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:	ISTRUCTION	(X3) DATE SURVEY COMPLETED:
		NTP001061			12/17/2024
NAME OF PROVI	DER OR SUPPLIER		STREET ADDRESS, C	CITY, STATE, ZIP CODE	-
NEW START TR	EATMENT, LLC		600 SOUTH 8TH ST GRIFFIN GA 30224		
44RD 1029 SS=D	implement written employment and o program employee handled in accorda laboratory practice related drugs, ampl THC, and other dru the results retained 26-5-2 et. seq., 31-3. This RULE is not me A review of the following A review of that Staff D, documentati screening.  In an intervient the management of the screening.	ting. Programs shall establish and policies and procedures for prengoing random drug testing of all seach sample must be collected and nee with accepted standards of clinical and tested for opiates, methadone and netamines, cocaine, benzodiazephines, gs with satisfactory documentation of by the program. Authority: O.C.G.A. §§ 2-5 and 31-2-7. 111-8-53 at as evidenced by:  The staff records revealed information:  The staff records revealed F, G, and H did not have on of a random drug  The staff B stated that the tuments could not be		Plan of Correction: To address the Staffing deficiencies identified audit, the following continuous actions will be implemed for the practices: Random drug screening documentation for Staff and H will be obtained to their personnel file of 1st quarter 2025.  2. Staff Training: Management will receive on proper drug testing documentation procedured a quarterly audit of drecords to ensure complementation program policies and refused to the program sponsor of Completion Date: December 2025	in the prrective ented:  The D, F, G, and added es by end  E training es.  implement rug testing liance with equilations.  O will rion of plan.
	The assessment muexamination in accessandards of medic tests, including dru consents to be test pregnancy, STD, an dependence on opiderivative or synthe determine current lassessments shall be substitution, short-detoxification, or diappropriate treatmestablish additional needs of the patien examination being the individual may examination, dated performed by a phy State of Georgia. State of Georgia. State of Georgia is necessary to reflect the time of admission that the substitution of the substituti	REENING, ASSESSMENT, & ADMISSION.  Ist include: 5. An in-person physical produce with current and accepted all practice, complete with laboratory graces, HIV status (if the applicant ed), CBC and chemistry profile, and did Mantoux TB tests, to determine tum, morphine, heroin, or any edic drug of that group and to DSM diagnosis. The purpose of such the to determine whether narcotic term detoxification, long-term tug-free treatment will be the most ent modality for the patient and to educational, vocational, and treatment t. In lieu of a complete physical performed by the program physician, present a complete physical within 90 days of admission, sician licensed in good standing in the such examination shall be updated as the individual's current condition at on, including updated laboratory tests.  10) sample client charts following information:		To address the deficiencie identified in the Patient Sc Assessment and Admissio the following corrective a be implemented: 1. Correction of Deficient  STD/RPR tests will be obt. Clients #1, #2, #3, #4, #7 and added to their medical by January 31, 2025.  2. Staff Training:  Clinical staff will be trained importance of documenting required tests upon patient admission, particularly ST tests.	creening, n areas, ctions will  Practices: ained for , and #10 al records  ed on the ng all tt

State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



1/15/25

#### State of GA, Healthcare Facility Regulation Division

0 17 11 21 11 21 11 01 2 21 10 21 10 22		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED:
		NTP001061			12/17/2024
NAME OF PROVI	DER OR SUPPLIER		STREET ADDRESS, (	CITY, STATE, ZIP CODE	
NEW START TRI	EATMENT, LLC		600 SOUTH 8TH S GRIFFIN GA 30224		
44RD 1213 SS=E	- and showe admission. Client #2 wa	s admitted on 7/07/2024 d no STD/RPR test upon s admitted on 7/24/2024 d no STD/RPR test upon	1213	3. Monitoring: The clinical supervise designee will perform monthly chart audits ensure proper documen of all necessary test	to tation
	- and showe admission.	s admitted on 7/17/2024 d no STD/RPR test upon s admitted on 9/18/2024		4. Responsible Part The Medical Director was responsible for oversethe corrective actions ensuring compliance.	will be eeing
		d no STD/RPR test upon		Completion Date: Janua 2025	ary 31,
		s admitted on 7/24/2024 no STD/RPR test upon			
	11/29/2024-	vas admitted on and showed no st upon admission.			
	a.m., Staff B	ew on 12/11/2024 at 9:41 stated that the missing could not be produced.			



TITLE CEO (X6) DATE

1/15/25

## DCH/ HFR site visit results

**YEAR 2023** 

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		NTP001061	B. WING		12/0	6/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NEW ST	ART TREATMENT, LL	.C 600 SOUT	TH 8TH STRI	EET		
	OURANA DV OTA		GA 30224	DDO//DEDIO DI ANI OF CODDECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
Z 000	INITIAL COMMENT	-S.	Z 000	Provider plan of Correction: Section 111-8-5309(1)		Complete date: 12/6/23
		visit was to conduct a on. The following rule d:		Corrective Action: The Policies an Procedures will be updated by the Policies of the policies for program admission. Prosponsor will update annually and ongoing to keep the P&P updated. will be conducted at minimum annureview the Policy and Procedures.	od Program opulation gram monitor Training	
Z 900 SS=D	111-8-5309(1) ADI	MINISTRATION.	Z 900			
	program shall opera rules, under written define its philosoph orientation, and pro procedures must id drug-dependent ind	ogram Purpose. A licensed ate, in accordance with these policies and procedures that y, purpose, program accedures. Such policies and entify the types of lividuals and the ages of the ogram serves, including				
	Based on record re- facility failed to defination program orientation policies and proced drug-dependent income	net as evidenced by: view and staff interview the ne its philosophy, purpose, n, and procedures. Such ures must identify the types of lividuals and the ages of the ogram serves, including ndings include:		Provider plan of Correction: Section_111-8-5309(3) Budgets for the NTP are created ar The responsible party is the Progra Sponsor to update and monitor. (co	ınually. ım	12/6/23
		ility policies and procedures se did not include client ages.				
		2/06/2023 at 9:19 a.m., Staff ng documentation could not time of the survey.				
Z 902 SS=D	111-8-5309(3) ADI	MINISTRATION.	Z 902			
<b>3</b> 3=D	the preparation of a	erning body shall provide for n annual budget and approve s of the current year's budget				

### State of GA, Healthcare Facility Regulation Division

PRINTED: 12/07/2023 FORM APPROVED

State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S

Shawn Madgett

(X6) DATE

TITLE: Program Sponsor

12/30/23

STATE FORM

5N0511

If continuation sheet 1 of

State of GA, Healthcare Facility Regulation Division

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NTP001061	B. WING		12/06/2023
	PROVIDER OR SUPPLIER	C 600 SOUT	DRESS, CITY, FITH 8TH STR	STATE, ZIP CODE EET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
Z 902	and expenditure rec to the Department t the Department upo	cords must be made available for examination and review by	Z 902	At the time of the survey the Progra Sponsor who handles the financials present (family emergency) therefo evidence of a written budget could obtained. <b>Corrective action:</b> A wri budget for calendar year 2023 was completed by the responsible party Program Sponsor, in January 2023	s was not ore not be tten
	Based on record re facility failed to provourrent year's budg must be made avai	view and staff interview, the vide documentation of a et and expenditure records lable to the Department for view by the Department upon		attached for written documentation	1.
		2/06/2023 at 9:19 a.m., Staff ng documentation could not time of the survey.			
Z 923 SS=D	Personnel Records	. A program shall maintain	Z 923		
	Each employee file (a) Identifying informaddress, current tell emergency contact (b) A five-year employment history five years; (c) Evidence of a contact from a state or locate reflects the individual convictions of a crir	mation including name, current ephone number, and		Provider plan of Correction: Section 111-8-5309(8) Corrective action: a secondary wi available for an authorized manage access personnel records in the event of the program Sponsor is not available. The program Sponsor is the Program Secondary is the Program Secondary in the program Secondary is the Program Secondary in the reviewed quarterly by the Personnel records for each staff median by the reviewed quarterly by the Personsor to ensure it is in compliant the regulations as outlined.	er to rent the The Sponsor. ember Program

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State of GA, Healthcare Facility Regulation Division

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(3) DATE SURVEY COMPLETED		
		NTP001061	B. WING		12	/06/2023
	PROVIDER OR SUPPLIER	C 600 SOUT	DRESS, CITY, S TH 8TH STRE GA 30224	ETATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Z 923	years; for employees capacity who are n and for employees the program may a which includes con such as those lister (d) Records of educapplicable; (e) Date of employr (f) The person's job the person's duties (g) Documentation required by these r (h) Any records releptormance, include status of the emploid (i) Evidence that ar	es working in an administrative of providing care to patients working as peer counselors, except a criminal record check viction of a nonviolent crime of in 111-8-5303(f)(12)-(17); exational qualifications if the ment; a description or statements of and responsibilities; of training and orientation rules; 111-8-53 evant to the employee's ding an appropriate health the syee; and my professional license tion of employment is current	Z 923			12/6/23
	Based on record re facility failed to mai records for each en shall include:  (a) Identifying informaddress, current te emergency contact (b) A five-year emplemployment history five years.  (c) Evidence of a confrom a state or local reflects the individuation convictions of a crired records from a state or local reflects the individuation convictions of a crired records from a state or local reflects the individuation of a crired records from a state or local reflects the individuation of a crired records from a state or local reflects the individuation of a crired records from a state or local reflects the individual convictions of a crired records from the facility of the state of th	net as evidenced by: view and staff interview the ntain written and verified nployee. Each employee file mation including name, current lephone number, and persons. loyment history or a complete vif the person has not worked riminal record check obtained I law enforcement agency that hal does not have any me, as defined in paragraph (f) 13, within the previous five				

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State of GA, Healthcare Facility Regulation Division

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NTP001061	B. WING		12/06/2023
	PROVIDER OR SUPPLIER	600 SOUT	DRESS, CITY, STH 8TH STR	STATE, ZIP CODE EET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
Z 923	years; for employees capacity who are no and for employees the program may awhich includes consuch as those listed (d) Records of educapplicable.  (e) Date of employr (f) The person's job the person's duties (g) Documentation required by these run (h) Any records releperformance, include status of the emplo (i) Evidence that an as a condition of er good standing.  Findings include:  In an interview on 1 multiple times through, and owner by te	es working in an administrative of providing care to patients working as peer counselors, except a criminal record check viction of a nonviolent crime of in 111-8-5303(f)(12)-(17); exational qualifications if the interval of and responsibilities. Of training and orientation cules; 111-8-53 evant to the employee's ling an appropriate health	Z 923		
Z1207 SS=D	ASSESSMENT, & A Assessment. Each program must be a director, the progra appropriately licens the medical staff wh qualified by law, ed experience to perfo	patient admitted to the ssessed by the medical	Z1207	Provider plan of Correction: Section 111-8-5312(1)(b) PATIEN SCREENING, ASSESSMENT, & ADMISSION  Corrective action: Client will be as by Medical staff during initial intake deemed eligible for treatment and intreatment is appropriate for client.	ssessed to be

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State of GA, Healthcare Facility Regulation Division

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
		NTP001061	B. WING		12/0	06/2023
	PROVIDER OR SUPPLIER  ART TREATMENT, LL	C 600 SOUT	DRESS, CITY, TH 8TH STR	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
Z1207	a patient for a main the most appropriate any medication is patient who is admit assessed by the maphysician, or an appropriate of the most appropriate of the provided in the program of the program must be medical staff which qualified by law, edexperience to perform the most of the program of the medical staff which program of t	tenance program unless it is the treatment modality. Before prescribed or administered, a litted to a program shall be redical director, the program propriately licensed and if the medical staff who has to be qualified by law, and experience to perform or vision of such assessments.  The tas evidenced by:  The tas evide	Z1207	Responsible Party: Clinical Super This process will be monitored by t Clinical Supervisor and a full audit conducted on a quarterly basis. Tr will include the nurse and MD to re findings of audit to ensure the documentation is in accordance wir regulatory requirements.	he will be raining view	12/6/23
	a client for a mainted the most appropriated any medication is publication is publication is admitted assessed by the maphysician, or an appropriate appropriate and the education, training, coordinate the provential production include:  A review of client re #3, #4, #9, and #10 assessment at the education in th	enance program unless it is the treatment modality. Before prescribed or administered, and ed to a program shall be edical director, the program propriately licensed and for the medical staff who has a be qualified by law, and experience to perform or inision of such assessments.				

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State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	:	COMPT	LILD
		NTP001061	B. WING		12/0	6/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
NEW ST	ART TREATMENT, LL	C 600 SOUT	TH 8TH STR	EET		
		GRIFFIN,	GA 30224			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
Z1207	Continued From pa	ge 5	Z1207			1
	assessment did no listed.	t have a completion date				
		3/22/2023, screening ompleted on 3/24/2023.				ı
	Clients #3, #9, and documentation of a time of admission.	#10 did not have screening assessment at the				
		2/06/2023 at 6:40 a.m., Staffing documentation could not time of the survey.				
Z1213 SS=D	111-8-5312(1)(b)5 ASSESSMENT, & The assessment m		Z1213	Note the records to show client #5 client #6 both admitted during 2020 under this ownership. Change of overcurred August 2021	was not	
	5. An in-person phaccordance with curof medical practice tests, including dru applicant consents chemistry profile, a Mantoux TB tests, opium, morphine, synthetic drug of the current DSM diagn assessments shall narcotic substitutio long-term detoxifica will be the most apfor the patient and educational, vocati the patient. In lieu examination being physician, the indiviphysical examination	ysical examination in rrent and accepted standards, complete with laboratory g screens, HIV status (if the to be tested), CBC and nd pregnancy, STD, and to determine dependence on neroin, or any derivative or at group and to determine osis. The purpose of such be to determine whether n, short-term detoxification, ation, or drug-free treatment propriate treatment modality to establish additional onal, and treatment needs of of a complete physical performed by the program idual may present a complete on, dated within 90 days of need by a physician licensed in		Provider plan of Correction: Section 111-8-5312(1)(b)5. PATIE SCREENING, ASSESSMENT, & ADMISSION. Corrective action: A member of the medical team (e.g. Nurse, CMA, MI medical assistant) will perform rapid before time of admission to verify e for treatment. Additionally, Urine sate be sent to Lab within 3 business d Copy of Rapid UDS to include Nam DOB will be placed in chart upon completion (within 24 hrs). Physica assessment by the Medical team for by. A memo will be included in the chart to note that DCH audit found information provided prior to owner not included. Due to Covid timing for physical examination will be out of sections.	ne D, d UDS ligibility Imple will ays. ne and I billowed client the ship was	

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State of GA, Healthcare Facility Regulation Division

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NTP001061	B. WING		12/06/2023
	PROVIDER OR SUPPLIER  ART TREATMENT, LL	C 600 SOUT	DRESS, CITY, STH 8TH STR	STATE, ZIP CODE EET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	O BE COMPLETE
Z1213	good standing in the examination shall be reflect the individual time of admission, it tests.  This RULE is not measured as a second of the care and chemistry and Mantoux TB to an opium, morphine synthetic drug of the current DSM diagneassessments shall narcotic substitution long-term detoxification will be the most appropriate the client. In lieu of examination being physician, the individual physical examination shall be reflect the individual to the control of the client.	e State of Georgia. Such ie updated as necessary to il's current condition at the including updated laboratory  net as evidenced by: view and staff interview, the wan in-person physical ordance with current and of medical practice, complete s, including drug screens, HIV ant consents to be tested), r profile, and pregnancy, STD, sts, to determine dependence e, heroin, or any derivative or at group and to determine osis. The purpose of such be to determine whether in, short-term detoxification, ation, or drug-free treatment coropriate treatment modality establish additional onal, and treatment needs of a complete physical performed by the program idual may present a complete on, dated within 90 days of ed by a physician licensed in e State of Georgia. Such ie updated as necessary to il's current condition at the including updated laboratory	Z1213	Orientation/consent forms to be dis reviewed and signed. Treatment op be explained, discuss detox rights a options, fees, and additional service discussed during intake. UDS inclurandom, HIV, STD and PPD educa options will take place during initial intake. The <b>Nurse</b> is the responsibl to monitor compliance and is the designated personnel for training.	itions will and es will be ding tion and
		cords revealed the following:			

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State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		NTP001061	B. WING		12/0	06/2023
	PROVIDER OR SUPPLIER	STREET AD 600 SOU	DRESS, CITY, S TH 8TH STRI GA 30224	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z1213	Clients # 1, #6, and documentation of a Clients # 2, #3, #4, not have document Clients #1, #2, #4, documentation shows the complete of the com	#10 did not have HIV training.  #5, #6, #7, #9, and #10 did fation of a TB and STD  #9, and #10 did not have wing a physical examination.  03/22/2023 and physical ated for 03/24/2023.  n 3/15/ 2023 and physical ated for 03/21/2023.  ##10 did not have B test was completed.  #10 did not have TD/RPR testing was  10/13/2023 and the RPR was #2023.  3/22/2023 and the RPR was /2023.  5/22/2020 and the TB was /2020.  2/05/2020 and TB was /2020.  3/01/2023 and RPR was /2020.  3/01/2023 and RPR was /2023.  2/06/2023 at 6:40 a.m., Staff ing documentation could not	Z1213			

State of GA Inspection Report STATE FORM

STATE FORM 6899 5N0511 If continuation sheet 8 of 15

State of GA, Healthcare Facility Regulation Division

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
			7. BOILDING	·		
		NTP001061	B. WING		12/0	6/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW ST	ART TREATMENT, LL	.C	TH 8TH STR	EET		
0.441.45	CLIMANA DV. CTA		GA 30224	DDOWDEDIO DI ANI OF CODDECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
				Provider plan of Correction:		12/15/23
Z1220 SS=D	ASSESSMENT, &		Z1220	Section# 111-8-53-12(1) (c) 3 Patie Screening, Assessment, and Admis Corrective action:	ssion	
		ogram shall provide orientation		- Upon intake, this organ		
		admitted for treatment within ion. Orientation must be done		will first verify if candida		
		ho has been determined to be		eligible for treatment by		
	qualified by educati	on, training, and experience to		providing a rapid UDS.  - Once individual has be		
		atients must be reoriented as		approved for treatment	-	
	program.	an understanding of the		medical team, and has	-	
	program.			their physical examinat		
				he/she will be provided		
	This RIII F is not n	net as evidenced by:		documents of		
		view and staff interview the		orientation/consent form	ns	
		vide orientation to the client		within 24 hrs of admis	ssion to	
	within 24 hours of a	dmission. Finding include:		review and sign.		
	A review of client re	ecords revealed that clients #2,		<ul> <li>Explanation of treatment</li> </ul>	nt	
	#4, #9, and #10 did	I not receive orientation within		options, detox rights, p	•	
	24 hours of admiss	ion.		charges, and any addit		
	Client # 2 admin da	te: 7/26/2023, did not have		service will be discusse		
		of receiving orientation.		time of orientation/asse		
	Client # 4 admin da	te: 3/22/ 2023, the orientation		Rules regarding client of		
	was on file but had			and responsibilities will		
	on file but had no	01/2023, the orientation was		reviewed. Once explan has been completed re		
	Client #10 admin: 3	/15/2023, did not have any		drug screening, HIV ed	-	
	documentation of re	eceiving orientation.		community awareness,		
	In an interview on 1	2/06/2023 at 6:40 a.m., Staff		other treatment, client		
		ng documentation could not		intake coordinator/ cou		
	be produced at the			will sign and date all	,	
Z1300 SS=D	111-8-5313 INDIV	IDUAL TREATMENT PLAN.	Z1300	documents.	د- لممس	
<del>-</del>		nt Plan. A program must ary individual treatment plan for		This process will be monito least <b>monthly</b> by the <b>Treat</b>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		NTP001061	B. WING		12/06/2023	
NEW START TREATMENT, LLC 600 SOUT		DRESS, CITY, STATE, ZIP CODE TH 8TH STREET GA 30224				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE	
Z1300	each patient within 10 days of admission, which includes an initial treatment recommendation. A complete individual treatment plan for each patient must be developed within 30 days of admission. Patients must be involved in the development of their treatment plans. Treatment plans must document a consistent pattern of substance abuse treatment services and medical care appropriate to individual patient needs and must meet the requirements of 42 C.F.R. § 8.12(f)(4).			Services Coordinator who designated responsible par audits, maintaining complia training. Initial training will be conducted during review of minimum annually.  Note, the records to show client #6 during 2020 was not under this own Change of ownership occurred Aug 2021.  Provider plan of Correction: Section: 111-8-5313 INDIVIDUAL	ty for unce and one P&P at both mership.	
	Based on a review interview it was det to develop a prelim for each client within complete individual within 30 days of an A review of client re #6, and #7 did not preliminary individu patient within 10 da Clients #2 admin or treatment plan was Client # 6 admin on documentation of a completed.  Clients #1, #2, #3, # have documented individual treatment	net as evidenced by: of facility records, and staff ermined that the facility failed nary individual treatment plan in 10 days of admission, and a treatment plan for each client dmission. Findings include.  cords revealed that clients #2, have documentation of a all treatment plan for each hys of admission.  in 7/26/2023 and the initial completed on 8/09/2023.  2/05/2020 and did not have in initial treatment plan  10/13/20203 and initial completed on 11/08/2023.  #5, #6, #7, #9 and #10 did not evidence that a complete t plan was developed and (30) days of admission.		TREATMENT PLAN  Corrective Action: The Initial Treat Plan to be conducted within 10 day forms for NST will be completed wir rules and regulations as set forth by We will continue to transition from put charts to the full utilization of the Mosystem where all of our documents electronic signatures will be housed utilize the schedule feature in Methoflag clients for treatment reviews. To responsible party to provide the review be the Counselor and/or Clinical Director. System flags will be utilize stay abreast of timelines of treatment frequency of the treatment plan will day, 30-day, 90-day and annually and 1. the Treatment Services Coording will review and audit charts on an obasis for missing items, communicated are provided by the Program Sponsor.	atment ays thin the y DCH. caper ethasoft with d. We will asoft to he riew will ed to nt. The be 10- fter year nator ongoing ate to gs within	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA				DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED	
		NTP001061	B. WING		12/0	6/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADI			DRESS, CITY, S	STATE, ZIP CODE			
NEW ST	ADT TOEATMENT II	600 SOUT	TH 8TH STR	EET			
NEW 31	ART TREATMENT, LL	GRIFFIN,	GA 30224				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETE DATE		
Z1300	Continued From page 10		Z1300				
	documented evider treatment plan was days of admission.  Client # 3 was admindividualized treatment 11/15/2023.  Client #7 was adminimation was adminimation was adminimation was adminimation.	#6, #9, and #10 did not have note that a complete individual developed with thirty (30) ain on 10/13/2023 and ment plan was completed on the initial on 10/13/2023 and ment plan was completed on ment plan was completed on					
Z1302 SS=D	A, stated that missi be produced at the	2/06/2023 at 6:40 a.m., Staffing documentation could not time of the survey.	Z1302	Provider plan of Correction: Section# 111-8-53-13(b) Individual Treatment Plan		12/7/23	
	patients, the case he plans must be reviet patients in treatment least annually for pone year. This reviet medical director or the primary counse members of the trequality controls and appropriateness of treatment on an on also include an asset dosage and scheduprogress of the patients.	continuing the form of going basis. This review must sessment of the current ule and the rehabilitative ient, as part of determination all medical services are		Corrective Action:  - This organization will dan individual treatment recommendation plan for new clients within 10 cadmission.  - Following, clients will was counselors to develop a treatment plan within 3 of admission. Each play have a pattern that incles substance abuse service medical care appropriation individual.	for all days of  vork with a 30 days an will ludes ces and		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
		NTP001061	B. WING		12/0	6/2023	
		DDESS CITY	STATE, ZIP CODE				
		600 SOUT	TH 8TH STR				
NEW ST	ART TREATMENT, LL	.C	GA 30224				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE	
Z1302	Continued From page 11		Z1302				
	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 RULE is not met as evidenced by: Based on record review and staff interview, the facility failed to review individual treatment plans every ninety (90) days for clients who were in the program less than one year and at least annually for clients in treatment more than one year. Findings include:  A review of client records revealed.  The clients #4, #5, #6, #9, and #10 did not have the ninety (90) day review for the first-year			<ul> <li>Patient will be educated in HI risk reduction.</li> <li>If appropriate each treatment plan will discuss, vocational, skill training, employment, legal, mental health, and soci leisure services/peer support</li> <li>Also, including phase, medication management, and relapse prevention.</li> <li>Each plan will be reviewed 9 days after admissions until the individual has met a year of treatment. At that time an annual treatment plan will be developed.</li> </ul>			
		n annual review. 2/06/2023 at 6:40 a.m., Staff ing documentation could not		The Responsible party for timely re will be the <b>Counselor/ Clinical Dir</b> For compliance and ongoing training responsible party will be the <b>Treatm Services Coordinator</b>	ector. ig, the		
Z1601 SS=D	These policies and following provisions (a) Clinically appro in accordance with standards of medic initially upon admis bi-weekly for new p of treatment and at	procedures must include the serior prize drug-screen tests done current and accepted all practice must be conducted assion and on a random basis patients during the first 30 days a least monthly thereafter.	Z1601	Provider plan of Correction: Section:_111-8-5316(a) DRUG-S TESTS Corrective Action: Rapid UDS are to be completed pri intake to determine eligibility and al to lab for confirmation. New clients, the first 30 days will be tested Bi-w including random UDS. Spreadshe created with Name, Date of screen results will assist with tracking of al and dates needed. Final UDS place	or to so sent during eekly, et / Log and I UDS	12/7/23	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		NTP001061	B. WING		12/0	6/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADI				STATE, ZIP CODE			
NEW ST	ART TREATMENT, LL	C	TH 8TH STR GA 30224	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPROPERTY (CROSS)	D BE	(X5) COMPLETE DATE	
Z1601	Continued From page 12 the drug-screen tests will be returned to a bi-weekly schedule for at least two weeks or longer if clinically indicated;  This RULE is not met as evidenced by: Based on record and staff interviews, the facility failed to clinically appropriate drug-screen tests done in accordance with current and accepted standards of medical practice must be conducted initially upon admission and on a random basis bi-weekly for new patients during the first 30 days of treatment and at least monthly thereafter. However, patients on a monthly schedule who fail the drug-screen tests will be returned to a bi-weekly schedule for at least two weeks or longer if clinically indicated. Findings include:		Z1601	binder after MD signs and date. The responsible party is Nurse to ensure all screens are completed timely and placed in the centrally located binder for staff access Nurse is also responsible for training of UDS screening process to additional personnel i.e. Medical Receptionist for support. The Treatment Services  Coordinator will conduct chart audit reviews on an ongoing basis to ensure compliance. Additionally, this training will b conducted as part of our New employee orientation and thereafter part of Policy and Procedure training conducted at minuimum annually.			
Z1700 SS=D	documentation of a time of admission.  Clients #4, #7, and documentation of a drug screening.  Clients # 1, #3, #4, any documentation screenings.  In an interview on 1 A, stated that missible produced at the 111-8-5317(1) QU  Quality Improvementation of a drug screening.	#7, #9, and #10 did not have of any random drug  2/06/2023 at 6:40 a.m., Staff ng documentation could not	Z1700	Provider plan of Correction: Section: 111-8-5317(1) QUALITY IMPROVEMENT Corrective Action: A written Quality Improvement Plar produced and documented in acco with regulatory requirements of the and CARF standards. This will be a collective team effort throughout all the organization. Responsible party the Program Sponsor. He/she will as the facilitator and point for comp information for documentation and execution. Discussions regarding w	n will be rdance DCH a lareas of y will be serve billing all	12/31/23	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
NTP001061		B. WING		12/06/2023			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
NEW ST	ART TREATMENT, LL	C	TH 8TH STR GA 30224	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
Z1700	that provides for the accordance with accordance of record refacility failed to developed unable of care in a standards of practice.  A review of the fact documentation of Canadards of practice standards of practice.  In an interview on 1	e delivery of care in cepted standards of practice.  net as evidenced by: view and staff interview the elop and implement a written at plan that provides for the accordance with accepted ce. Findings include: ility failed to provide equality Improvement Plan, that in accordance with accepted ce.  2/06/2023 at 9:19 a.m., Staff ng documentation could not	Z1700	Commence during quality assurance meetings held <b>quarterly</b> . A Quality Assurance Policy will be created to areas of improvement, client satisfastaff retention, etc.	address		

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