DCH/ HFR site visit results

YEAR 2024

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED:
	NTP001061	A. BUILDING:	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW START TREATMENT, LLC	**600 SOUTH 8TH STREET GRIFFIN GA 30224**

44RD 0923 SS=E	0923 - ADMINISTRATION. Personnel Records. A program shall maintain written and verified records for each employee. Each employee file shall include: (a) Identifying information including name, current address, current telephone number, and emergency contact persons; (b) A five-year employment history or a complete employment history if the person has not worked five years; (c) Evidence of a criminal record check obtained from a state or local law enforcement agency that reflects the individual does not have any convictions of a crime, as defined in paragraph (f) of Rule 111-8-53-.03, within the previous five years; for employees working in an administrative capacity who are not providing care to patients and for employees working as peer counselors, the program may accept a criminal record check which includes conviction of a nonviolent crime such as those listed in 111-8-53-.03(f)(12)-(17); (d) Records of educational qualifications if applicable; (e) Date of employment; (f) The person's job description or statements of the person's duties and responsibilities; (g) Documentation of training and orientation required by these rules; 111-8-53 (h) Any records relevant to the employee's performance, including an appropriate health status of the employee; and (i) Evidence that any professional license required as a condition of employment is current and in good standing. This RULE is not met as evidenced by: A review of the staff records revealed the following information: A review of the staff records revealed that Staff F did not have documentation of a five-year employment history on file. A review of the staff records revealed that Staff D and G did not have documentation of an annual job performance evaluation on file. A review of the staff records revealed that Staff G did not have documentation of a health status on file. In an interview on 12/11/2024 at 11:18 a.m., Staff B stated that the missing documents could not be produced.	0923	To address the Administration deficiencies identified in the audit, the following corrective actions will be implemented: 1.Correction of Deficient Practices: Staff F's employment history will be obtained and added to their personnel file by January 1, 2025. Staff D and G will undergo annual job performance evaluations, with documentation added to their personnel files by February 15, 2025. A health status document will be obtained for Staff G and added to their personnel file by December 31, 2025. 2.Staff Training: All supervisory staff will be trained on proper documentation procedures to ensure complete personnel records. 3.Monitoring: HR representative will conduct a monthly audit of personnel records to ensure compliance, with results discussed during quarterly quality assurance meetings. 4.Responsible Party: The Program Sponsor/ CEO will be responsible for monitoring the implementation of this plan. Completion Date: January 17,2025	

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

State of GA, Healthcare Facility Regulation Division

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44RD 1029 SS=D	1029 - STAFFING. Employee Drug Testing. Programs shall establish and implement written policies and procedures for pre-employment and ongoing random drug testing of all program employees. Each sample must be collected and handled in accordance with accepted standards of clinical laboratory practice and tested for opiates, methadone and related drugs, amphetamines, cocaine, benzodiazephines, THC, and other drugs with satisfactory documentation of the results retained by the program. Authority: O.C.G.A. §§ 26-5-2 et. seq., 31-2-5 and 31-2-7. 111-8-53 This RULE is not met as evidenced by: A review of the staff records revealed the following information: A review of the staff records revealed that Staff D, F, G, and H did not have documentation of a random drug screening. In an interview on 12/11/2024 at 11:18 a.m., Staff B stated that the missing documents could not be produced	1029	Plan of Correction: To address the Staffing deficiencies identified in the audit, the following corrective actions will be implemented: 1.Correction of Deficient Practices: Random drug screening documentation for Staff D, F, G, and H will be obtained and added to their personnel files by end of 1st quarter 2025. 2.Staff Training: Management will receive training on proper drug testing documentation procedures. 3.Monitoring: HR representative will implement a quarterly audit of drug testing records to ensure compliance with program policies and regulations. 4.Responsible Party: The Program Sponsor/ CEO will monitor the implementation of this corrective action plan. Completion Date: December 17, 2025	
	1213 - PATIENT SCREENING, ASSESSMENT, & ADMISSION. The assessment must include: 5. An in-person physical examination in accordance with current and accepted standards of medical practice, complete with laboratory tests, including drug screens, HIV status (if the applicant consents to be tested), CBC and chemistry profile, and pregnancy, STD, and Mantoux TB tests, to determine dependence on opium, morphine, heroin, or any derivative or synthetic drug of that group and to determine current DSM diagnosis. The purpose of such assessments shall be to determine whether narcotic substitution, short-term detoxification, long-term detoxification, or drug-free treatment will be the most appropriate treatment modality for the patient and to establish additional educational, vocational, and treatment needs of the patient. In lieu of a complete physical examination being performed by the program physician, the individual may present a complete physical examination, dated within 90 days of admission, performed by a physician licensed in good standing in the State of Georgia. Such examination shall be updated as necessary to reflect the individual's current condition at the time of admission, including updated laboratory tests. This RULE is not met as evidenced by: A review of (10) sample client charts revealed the following information:		To address the deficiencies identified in the Patient Screening, Assessment and Admission areas, the following corrective actions will be implemented: 1.Correction of Deficient Practices: STD/RPR tests will be obtained for Clients #1, #2, #3, #4, #7, and #10 and added to their medical records by January 31, 2025. 2.Staff Training: Clinical staff will be trained on the importance of documenting all required tests upon patient admission, particularly STD/RPR tests.	

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44RD 1213 SS=E	Client #1 was admitted on 7/07/2024 - and showed no STD/RPR test upon admission. Client #2 was admitted on 7/24/2024 - and showed no STD/RPR test upon admission. Client #3 was admitted on 7/17/2024 - and showed no STD/RPR test upon admission. Client #4 was admitted on 9/18/2024 - and showed no STD/RPR test upon admission. Client #7 was admitted on 7/24/2024 and showed no STD/RPR test upon admission. Client # 10 was admitted on 11/29/2024- and showed no STD/RPR test upon admission. In an interview on 12/11/2024 at 9:41 a.m., Staff B stated that the missing documents could not be produced.	1213	3. Monitoring: The clinical supervisor or a designee will perform monthly chart audits to ensure proper documentation of all necessary tests. 4. Responsible Party: The Medical Director will be responsible for overseeing the corrective actions and ensuring compliance. Completion Date: January 31, 2025	

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YEAR 2023

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	NTP001061	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW START TREATMENT, LLC	600 SOUTH 8TH STREET GRIFFIN, GA 30224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	INITIAL COMMENTS. The purpose of this visit was to conduct a compliance inspection. The following rule violation(s) were cited:	Z 000	**Provider plan of Correction:** Section 111-8-53-.09(1) **Corrective Action**: The Policies and Procedures will be updated by the Program Sponsor to clarify the ages of the population eligible for program admission. **Program sponsor** will update **annually and monitor ongoing** to keep the P&P updated. Training will be conducted at minimum annually to review the Policy and Procedures.	**Complete date: 12/6/23**
Z 900 SS=D	111-8-53-.09(1) ADMINISTRATION. Administration. Program Purpose. A licensed program shall operate, in accordance with these rules, under written policies and procedures that define its philosophy, purpose, program orientation, and procedures. Such policies and procedures must identify the types of drug-dependent individuals and the ages of the patients that the program serves, including referral sources. This RULE is not met as evidenced by: Based on record review and staff interview the facility failed to define its philosophy, purpose, program orientation, and procedures. Such policies and procedures must identify the types of drug-dependent individuals and the ages of the patients that the program serves, including referral sources. Findings include: A review of the facility policies and procedures the program purpose did not include client ages. In an interview on 12/06/2023 at 9:19 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z 900	**Provider plan of Correction:** Section 111-8-53-.09(3) Budgets for the NTP are created **annually**. The responsible party is the **Program Sponsor** to update and monitor. (continued on next page)	**12/6/23**
Z 902 SS=D	111-8-53-.09(3) ADMINISTRATION. Finances. The governing body shall provide for the preparation of an annual budget and approve such budget. Copies of the current year's budget	Z 902		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S

Shawn Madgett

TITLE: Program Sponsor

(X6) DATE

12/30/23

STATE FORM 6899 5N0511 If continuation sheet 1 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 902	Continued From page 1 and expenditure records must be made available to the Department for examination and review by the Department upon request. This RULE is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documentation of a current year's budget and expenditure records must be made available to the Department for examination and review by the Department upon request. Findings include: A review of the facility failed to provide documentation of an annual budget which includes expenditures available to the Department for examination. In an interview on 12/06/2023 at 9:19 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z 902	At the time of the survey the Program Sponsor who handles the financials was not present (family emergency) therefore evidence of a written budget could not be obtained. **Corrective action:** A written budget for calendar year 2023 was completed by the responsible party, Program Sponsor, in January 2023. **See attached** for written documentation.	
Z 923 SS=D	111-8-53-.09(8) ADMINISTRATION. Personnel Records. A program shall maintain written and verified records for each employee. Each employee file shall include: (a) Identifying information including name, current address, current telephone number, and emergency contact persons; (b) A five-year employment history or a complete employment history if the person has not worked five years; (c) Evidence of a criminal record check obtained from a state or local law enforcement agency that reflects the individual does not have any convictions of a crime, as defined in paragraph (f) of Rule 111-8-53-.03, within the previous five	Z 923	**Provider plan of Correction:** Section 111-8-53-.09(8) **Corrective action**: a secondary will be available for an authorized manager to access personnel records in the event the Program Sponsor is not available. The responsible party is the **Program Sponsor.** Personnel records for each staff member will be reviewed **quarterly** by the Program Sponsor to ensure it is in compliance with the regulations as outlined**.**	

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Z 923	Continued From page 2 years; for employees working in an administrative capacity who are not providing care to patients and for employees working as peer counselors, the program may accept a criminal record check which includes conviction of a nonviolent crime such as those listed in 111-8-53-.03(f)(12)-(17); (d) Records of educational qualifications if applicable; (e) Date of employment; (f) The person's job description or statements of the person's duties and responsibilities; (g) Documentation of training and orientation required by these rules; 111-8-53 (h) Any records relevant to the employee's performance, including an appropriate health status of the employee; and (i) Evidence that any professional license required as a condition of employment is current and in good standing. This RULE is not met as evidenced by: Based on record review and staff interview the facility failed to maintain written and verified records for each employee. Each employee file shall include: (a) Identifying information including name, current address, current telephone number, and emergency contact persons. (b) A five-year employment history or a complete employment history if the person has not worked five years. (c) Evidence of a criminal record check obtained from a state or local law enforcement agency that reflects the individual does not have any convictions of a crime, as defined in paragraph (f) of Rule 111-8-53-.03, within the previous five	Z 923		12/6/23

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Z 923	Continued From page 3 years; for employees working in an administrative capacity who are not providing care to patients and for employees working as peer counselors, the program may accept a criminal record check which includes conviction of a nonviolent crime such as those listed in 111-8-53-.03(f)(12)-(17); (d) Records of educational qualifications if applicable. (e) Date of employment. (f) The person's job description or statements of the person's duties and responsibilities. (g) Documentation of training and orientation required by these rules; 111-8-53 (h) Any records relevant to the employee's performance, including an appropriate health status of the employee; and (i) Evidence that any professional license required as a condition of employment is current and in good standing. Findings include: In an interview on 12/06/2023 at 5:15 a.m., and multiple times throughout the survey Staff A, D, F, G, and owner by telephone stated that missing documents could not be produced at the time of the survey.	Z 923		
Z1207 SS=D	111-8-53-.12(1)(b) PATIENT SCREENING, ASSESSMENT, & ADMISSION. Assessment. Each patient admitted to the program must be assessed by the medical director, the program physician, or an appropriately licensed and qualified member of the medical staff who has been determined to be qualified by law, education, training, and experience to perform or coordinate the provision of such assessments. A program shall not admit	Z1207	**Provider plan of Correction:** Section 111-8-53-.12(1)(b) PATIENT SCREENING, ASSESSMENT, & ADMISSION **Corrective action:** Client will be assessed by Medical staff during initial intake to be deemed eligible for treatment and if treatment is appropriate for client.	

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Z1207	Continued From page 4 a patient for a maintenance program unless it is the most appropriate treatment modality. Before any medication is prescribed or administered, a patient who is admitted to a program shall be assessed by the medical director, the program physician, or an appropriately licensed and qualified member of the medical staff who has been determined to be qualified by law, education, training, and experience to perform or coordinate the provision of such assessments. This RULE is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that each client admitted to the program must be assessed by the medical director, the program physician, or an appropriately licensed and qualified member of the medical staff who has been determined to be qualified by law, education, training, and experience to perform or coordinate the provision of such assessments. A program shall not admit a client for a maintenance program unless it is the most appropriate treatment modality. Before any medication is prescribed or administered, a client who is admitted to a program shall be assessed by the medical director, the program physician, or an appropriately licensed and qualified member of the medical staff who has been determined to be qualified by law, education, training, and experience to perform or coordinate the provision of such assessments. Finding include: A review of client records revealed that clients #2, #3, #4, #9, and #10 did not receive screening assessment at the time of admission. Client #2 admin on 7/26/2023, screening	Z1207	Responsible Party: **Clinical Supervisor**. This process will be monitored by the Clinical Supervisor and a full audit will be conducted on a **quarterly** basis. Training will include the nurse and MD to review findings of audit to ensure the documentation is in accordance with regulatory requirements.	12/6/23

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Z1207	Continued From page 5 assessment did not have a completion date listed. Client #4 admin on 3/22/2023, screening assessment was completed on 3/24/2023. Clients #3, #9, and #10 did not have documentation of a screening assessment at the time of admission. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1207		
Z1213 SS=D	111-8-53-.12(1)(b)5. PATIENT SCREENING, ASSESSMENT, & ADMISSION. The assessment must include: 5. An in-person physical examination in accordance with current and accepted standards of medical practice, complete with laboratory tests, including drug screens, HIV status (if the applicant consents to be tested), CBC and chemistry profile, and pregnancy, STD, and Mantoux TB tests, to determine dependence on opium, morphine, heroin, or any derivative or synthetic drug of that group and to determine current DSM diagnosis. The purpose of such assessments shall be to determine whether narcotic substitution, short-term detoxification, long-term detoxification, or drug-free treatment will be the most appropriate treatment modality for the patient and to establish additional educational, vocational, and treatment needs of the patient. In lieu of a complete physical examination being performed by the program physician, the individual may present a complete physical examination, dated within 90 days of admission, performed by a physician licensed in	Z1213	Note the records to show client #5 and client #6 both admitted during 2020 was not under this ownership. Change of ownership occurred August 2021. **Provider plan of Correction:** Section 111-8-53-.12(1)(b)5. PATIENT SCREENING, ASSESSMENT, & ADMISSION. **Corrective action:** A member of the medical team (e.g. Nurse, CMA, MD, medical assistant) will perform rapid UDS before time of admission to verify eligibility for treatment. Additionally, Urine sample will be sent to Lab within **3 business days**. Copy of Rapid UDS to include Name and DOB will be placed in chart upon completion (within 24 hrs). Physical assessment by the Medical team followed by. A memo will be included in the client chart to note that DCH audit found the information provided prior to ownership was not included. Due to Covid timing for physical examination will be out of sync.	

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Z1213	Continued From page 6 good standing in the State of Georgia. Such examination shall be updated as necessary to reflect the individual's current condition at the time of admission, including updated laboratory tests. This RULE is not met as evidenced by: Based on record review and staff interview, the facility failed to show an in-person physical examination in accordance with current and accepted standards of medical practice, complete with laboratory tests, including drug screens, HIV status (if the applicant consents to be tested), CBC and chemistry profile, and pregnancy, STD, and Mantoux TB tests, to determine dependence on opium, morphine, heroin, or any derivative or synthetic drug of that group and to determine current DSM diagnosis. The purpose of such assessments shall be to determine whether narcotic substitution, short-term detoxification, long-term detoxification, or drug-free treatment will be the most appropriate treatment modality for the client and to establish additional educational, vocational, and treatment needs of the client. In lieu of a complete physical examination being performed by the program physician, the individual may present a complete physical examination, dated within 90 days of admission, performed by a physician licensed in good standing in the State of Georgia. Such examination shall be updated as necessary to reflect the individual's current condition at the time of admission, including updated laboratory tests. Findings include: A review of client records revealed the following:	Z1213	Orientation/consent forms to be discussed, reviewed and signed. Treatment options will be explained, discuss detox rights and options, fees, and additional services will be discussed during intake. UDS including random, HIV, STD and PPD education and options will take place during initial intake. The **Nurse** is the responsible person to monitor compliance and is the designated personnel for training.	12/15/23

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Z1213	Continued From page 7 Clients # 1, #6, and #10 did not have documentation of a HIV training. Clients # 2, #3, #4, #5, #6, #7, #9, and #10 did not have documentation of a TB and STD Clients #1, #2, #4, #9, and #10 did not have documentation showing a physical examination. Client #4 admin on 03/22/2023 and physical examination was dated for 03/24/2023. Client # 10 admin on 3/15/ 2023 and physical examination was dated for 03/21/2023. Clients # 2, #3, and #10 did not have documentation of TB test was completed. Clients # 2, #7 and #10 did not have documentation of STD/RPR testing was completed. Client #3 admin on 10/13/2023 and the RPR was completed on 10/18/2023. Client #4 admin on 3/22/2023 and the RPR was completed on 4/04/2023. Client #5 admin on 5/22/2020 and the TB was completed on 5/23/2020. Client #6 admin on 2/05/2020 and TB was completed on 3/06/2020. Client #9 admin on 3/01/2023 and RPR was completed on 3/03/2023. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1213		

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Z1220 SS=D	111-8-53-.12(1)(c)3. PATIENT SCREENING, ASSESSMENT, & ADMISSION. Orientation. The program shall provide orientation to patients who are admitted for treatment within 24 hours of admission. Orientation must be done by a staff person who has been determined to be qualified by education, training, and experience to perform the task. Patients must be reoriented as needed to ensure an understanding of the program. This RULE is not met as evidenced by: Based on record review and staff interview the facility failed to provide orientation to the client within 24 hours of admission. Finding include: A review of client records revealed that clients #2, #4, #9, and #10 did not receive orientation within 24 hours of admission. Client # 2 admin date: 7/26/2023, did not have any documentation of receiving orientation. Client # 4 admin date: 3/22/ 2023, the orientation was on file but had no dated. Client # 9 admin: 3/01/2023, the orientation was on file but had no dated. Client #10 admin: 3/15/2023, did not have any documentation of receiving orientation. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1220	**Provider plan of Correction:** Section# 111-8-53-12(1) (c)3 Patient Screening, Assessment, and Admission **Corrective action:** - Upon intake, this organization will first verify if candidate is eligible for treatment by providing a rapid UDS. - Once individual has been approved for treatment by medical team, and has had their physical examination he/she will be provided with documents of orientation/consent forms **within 24 hrs of admission** to review and sign. - Explanation of treatment options, detox rights, program charges, and any additional service will be discussed at time of orientation/assessment. Rules regarding client conduct and responsibilities will be reviewed. Once explanation has been completed regarding drug screening, HIV education, community awareness, and all other treatment, client and intake coordinator/ counselor, will sign and date all documents. This process will be monitored at least **monthly** by the **Treatment**	12/15/23
Z1300 SS=D	111-8-53-.13 INDIVIDUAL TREATMENT PLAN. Individual Treatment Plan. A program must develop a preliminary individual treatment plan for	Z1300		

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	NTP001061	A. BUILDING: _____ B. WING _____	12/06/2023

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Z1300	Continued From page 9 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). This RULE is not met as evidenced by: Based on a review of facility records, and staff interview it was determined that the facility failed to develop a preliminary individual treatment plan for each client within 10 days of admission, and a complete individual treatment plan for each client within 30 days of admission. Findings include. A review of client records revealed that clients #2, #6, and #7 did not have documentation of a preliminary individual treatment plan for each patient within 10 days of admission. Clients #2 admin on 7/26/2023 and the initial treatment plan was completed on 8/09/2023. Client # 6 admin on 2/05/2020 and did not have documentation of an initial treatment plan completed. Client #7 admin on 10/13/20203 and initial treatment plan was completed on 11/08/2023. Clients #1, #2, #3, #5, #6, #7, #9 and #10 did not have documented evidence that a complete individual treatment plan was developed and reviewed with thirty (30) days of admission.	Z1300	**Services Coordinator** who is the designated responsible party for audits, maintaining compliance and training. Initial training will be conducted during review of P&P at minimum annually. Note, the records to show client #6 both during 2020 was not under this ownership. Change of ownership occurred August 2021. **Provider plan of Correction:** Section: 111-8-53-.13 INDIVIDUAL TREATMENT PLAN **Corrective Action:** The Initial Treatment Plan to be **conducted within 10 days** forms for NST will be completed within the rules and regulations as set forth by DCH. We will continue to transition from paper charts to the full utilization of the Methasoft system where all of our documents with electronic signatures will be housed. We will utilize the schedule feature in Methasoft to flag clients for treatment reviews. The responsible party to provide the review will be the **Counselor and/or Clinical Director**. System flags will be utilized to stay abreast of timelines of treatment. The frequency of the treatment plan will be 10-day, 30-day, 90-day and annually after year 1. the **Treatment Services Coordinator** will review and **audit** charts on an ongoing basis for missing items, communicate to responsible party to clear all findings within **30-days**. This process will be overseen/managed by the **Program Sponsor**.	12/7/23

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Z1300	Continued From page 10 Clients #1, #2, #5, #6, #9, and #10 did not have documented evidence that a complete individual treatment plan was developed with thirty (30) days of admission. Client # 3 was admin on 10/13/2023 and individualized treatment plan was completed on 11/15/2023. Client #7 was admin on 10/13/2023 and individualized treatment plan was completed on 12/04/2023. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1300		
Z1302 SS=D	111-8-53-.13(b) INDIVIDUAL TREATMENT PLAN. In recognition of the varied medical needs of patients, the case history and individual treatment plans must be reviewed at least every 90 days for patients in treatment less than one year and at least annually for patients in treatment more that one year. This review will be conducted by the medical director or program physician along with the primary counselor and other appropriate members of the treatment team for general quality controls and evaluation of the appropriateness of continuing the form of treatment on an ongoing basis. This review must also include an assessment of the current dosage and schedule and the rehabilitative progress of the patient, as part of determination of whether additional medical services are indicated. If such review results in a	Z1302	**Provider plan of Correction:** Section# 111-8-53-13(b) Individual Treatment Plan **Corrective Action:** - This organization will develop an individual treatment recommendation plan for all new clients **within 10 days** of admission. - Following, clients will work with counselors to develop a treatment plan **within 30 days** of admission. Each plan will have a pattern that includes substance abuse services and medical care appropriate to the individual.	12/7/23

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Z1302	Continued From page 11 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 reviews. The clients #5 and #6 did not have documentation of an annual review. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1302	- Patient will be educated in HIV risk reduction. - If appropriate each treatment plan will discuss, vocational, skill training, employment, legal, mental health, and social leisure services/peer support. - Also, including phase, medication management, and relapse prevention. - Each plan will be **reviewed 90** days after admissions until the individual has met a year of treatment. At that time an annual treatment plan will be developed. The Responsible party for timely reviews will be the **Counselor/ Clinical Director**. For compliance and ongoing training, the responsible party will be the **Treatment Services Coordinator**	
Z1601 SS=D	111-8-53-.16(a) DRUG-SCREEN TESTS. These policies and procedures must include the following provisions: (a) 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	Z1601	**Provider plan of Correction:** Section: 111-8-53-.16(a) DRUG-SCREEN TESTS **Corrective Action:** Rapid UDS are to be completed prior to intake to determine eligibility and also sent to lab for confirmation. New clients, during the first **30 days** will be tested Bi-weekly, including random UDS. Spreadsheet / Log created with Name, Date of screen and results will assist with tracking of all UDS and dates needed. Final UDS placed in	12/7/23

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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: Clients #2, #3, #6, and #9, did not have documentation of an initial drug screening at the time of admission. Clients #4, #7, and # 10 did not have documentation of a completion date of the initial drug screening. Clients # 1, #3, #4, #7, # 9, and # 10 did not have any documentation of any random drug screenings. In an interview on 12/06/2023 at 6:40 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	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 be conducted as part of our New employee orientation and thereafter part of Policy and Procedure training conducted at minuimum annually. **Provider plan of Correction:** Section: 111-8-53-.17(1) QUALITY IMPROVEMENT **Corrective Action:** A written Quality Improvement Plan will be produced and documented in accordance with regulatory requirements of the DCH and CARF standards. This will be a collective team effort throughout all areas of the organization. Responsible party will be the **Program Sponsor**. He/she will serve as the facilitator and point for compiling all information for documentation and	**12/31/23**
Z1700 SS=D	111-8-53-.17(1) QUALITY IMPROVEMENT. Quality Improvement. Programs shall develop and implement a written quality improvement plan	Z1700	execution. Discussions regarding will	

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Z1700	Continued From page 13 that provides for the delivery of care in accordance with accepted standards of practice. This RULE is not met as evidenced by: Based on record review and staff interview the facility failed to develop and implement a written quality improvement plan that provides for the delivery of care in accordance with accepted standards of practice. Findings include: A review of the facility failed to provide documentation of Quality Improvement Plan, that addresses the care in accordance with accepted standards of practice. In an interview on 12/06/2023 at 9:19 a.m., Staff A, stated that missing documentation could not be produced at the time of the survey.	Z1700	Commence during quality assurance meetings held **quarterly**. A Quality Assurance Policy will be created to address areas of improvement, client satisfaction, staff retention, etc.	