Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
			A. BUILDING:		D D					
		MHL0601206	B. WING		R 04/02/2018					
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE						
MCLEOD ADDICTIVE DISEASE CENTER-4TH FLOOR										
(V.A.) ID	SHIMMADV ST.		OTTE, NC 28217	PROVIDER'S PLAN OF CORRECT	ION (VE)					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)  COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000							
	An annual and follow 2, 2018. A deficiency	up was completed on April was cited.								
	-	d for the following service								
	categories: 10A NCAC 27G .3100 Non-hospital Medical Detoxification for Individuals who are Substance Abusers and 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for									
Individuals with Substance Abuse Disorders.										
V 114	V 114 27G .0207 Emergency Plans and Supplies		V 114							
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be									
		ft. Drills shall be conducted								
		simulate fire emergencies. have basic first aid supplies								
	accessible for use.	navo bacio inot ala cappilos								
	This Rule is not met	as evidenced bv:								
Based on interview and record review, fire and										
	disaster drills were no repeated for each shi									
	•	-								
	Review on 4/2/18 of t									
	Disaster Drill Log reverse.  No 2nd or 3rd shift file	ealed: re drills for 4th Quarter								
	olth Service Degulation			l .						

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
					R					
		MHL0601206	B. WING		04/02/2018					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
MCLEOD ADDICTIVE DISEASE CENTER-4TH FLOOR  515 CLANTON ROAD, 4TH FLOOR  CHARLOTTE, NC 28217										
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE					
V 114	(October - December -No 3rd shift fire drill f March), 2017.  Interview on 4/2/18 w Assurance revealed: -There were no other what was in the Fire a	), 2017; or 1st Quarter (January -	V 114							

Division of Health Service Regulation

STATE FORM 6899 GMOQ11 If continuation sheet 2 of 2