Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	ORDECTION IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or contribution	BENTI IGATION NOMBER.	A. BUILDING:		OOWII EETEB
		MHL018-057	B. WING		R 03/07/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
MCLEOD	ADDICTIVE DISEASE CE	1170 FAIF	RGROVE CHURC	H ROAD	
WICLEOD	ADDICTIVE DISEASE CE	HICKORY	, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow on March 7, 2019. A	up survey was completed deficiency was cited.			
	category: 10A NCAC	d for the following service 27G .3600 Outpatient ne facility is currently serving			
V 536	27E .0107 Client Right Int.	nts - Training on Alt to Rest.	V 536		
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person o property damage is p (c) Provider agencies based on state compe compliance and demonstrate (d) The training shall include measurable le measurable testing (v behavior) on those of methods to determine course. (e) Formal refresher	plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in of imminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal constrate they acted on data			

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			
			B. WING		R			
		MHL018-057	B. WINO		03/07/2019			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MCLEOD	ADDICTIVE DISEASE CE	:NTER - HICKORY HICKORY,	GROVE CHUR(NC 28601	CH ROAD				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)				
V 536	Continued From page	e 1	V 536					
V 536	(f) Content of the trai provider wishes to enthe Division of MH/DD Paragraph (g) of this (g) Staff shall demonfollowing core areas: (1) knowledge apeople being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in assescalating behavior; (8) communication de-escalating pot and (9) positive behing and (9) positive behing activities which direct behaviors which are used (h) Service providers documentation of initiat least three years. (1) Documentation	ning that the service nploy must be approved by D/SAS pursuant to Rule. Istrate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and at that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; navioral supports (providing in disabilities to choose ly oppose or replace unsafe).	V 536					
	(B) when and w	where they attended; and						
	(C) instructor's(2) The Division	name; n of MH/DD/SAS may						

Division of Health Service Regulation

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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			
		MUI 049 057	B. WING R		2040			
NAME OF PROVI		MHL018-057		TE 7/D 00DE	03/07/2	2019		
NAME OF PROVI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1170 FAIRGROVE CHURCH ROAD							
MCLEOD ADD	DICTIVE DISEASE CE	ENTER - HICKORY HICKORY,						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE		
V 536 Co	ontinued From page	e 2	V 536					
rev (i) Re (1) by air ne (2) by ins (3) co ob ob me fai (4) se ap to (5) sh (A (B co (C pe (D (6) tea int rev (7) air ne an (8)	view/request this do Instructor Qualificate equirements: Trainers sha scoring 100% on the med at preventing, ed for restrictive in Trainers sha scoring a passing structor training proof The training mpetency-based, in jectives, measurable servation of behave easurable methods ling the course. The content rice provider plans proved by the Divist Subparagraph (i)(5) Acceptable all include but are in understandi (i) methods for urse; methods for formance; and (i) methods for rainers shading a training producing and eliminate erventions at least view by the coach. Trainers shad at preventing, ed for restrictive in nually. Trainers shading a training producing and eliminate erventions at least view by the coach. Trainers shad at preventing, ed for restrictive in nually.	all demonstrate competence esting in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an gram. It is shall be include measurable learning on those objectives and to determine passing or it of the instructor training the is to employ shall be ission of MH/DD/SAS pursuant						

Division of Health Service Regulation

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Division of Health Service Regulation

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	
					R	
		MHL018-057	B. WING		03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MCLEOD	ADDICTIVE DISEASE CE	INTER - HICKORY HICKORY,	ROVE CHURO NC 28601	CH ROAD		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 536	training for at least th (1) Docume (A) who particip outcomes (pass/fail); (B) when and v (C) instructor's (2) The Division request and review th (k) Qualifications of 0 (1) Coaches sh requirements as a tra (2) Coaches sh the course which is b (3) Coaches sh competence by comp train-the-trainer instru	shall maintain al and refresher instructor ree years. entation shall include: ated in the training and the where attended; and name. n of MH/DD/SAS may its documentation any time. Coaches: all meet all preparation iner. itall teach at least three times eing coached. itall demonstrate letion of coaching or	V 536			
	failed to ensure all sta alternatives to restrict providing services aff members (Counselor	nd record review, the facility aff received training in ive intervention prior to ecting 1 of 3 audited staff #25). The findings are:				
	revealed: -Hire date of 2/25/19;	ftraining in alternatives to				

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PRINTED: 03/09/2019 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER MICLEOD ADDICTIVE DISEASE CENTER - HICKORY MICLEOD ADDICTIVE DISEASE CENTER - HICKORY MICHORY, No. 2861 SUMMARY STATEMENT OF DEPTICIENCIES PRETENT PROVIDERS PLAN OF CORRECTION PRETENT PROVIDENT PROVIDENT		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SI COMPLE			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1170 FAIRGROVE CHURCH ROAD HICKORY, NC 28601 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 4 Interview on 3/7/19 with Counselor #25 revealed: -Had not received training in alternatives to restrictive intervention since starting at the facility. Interview on 3/7/19 with the Program Director revealed: -Will ensure Counselor #25 receives training in alternatives to restrictive intervention as soon as possible; -Will ensure all new staff receive training in alternatives to restrictive intervention prior to				B WING		1			
MCLEOD ADDICTIVE DISEASE CENTER - HICKORY 1170 FAIRGROVE CHURCH ROAD HICKORY, NC 28601			MHL018-057	B. WING		03/0	7/2019		
MCLEOD ADDICTIVE DISEASE CENTER - HICKORY HICKORY, NC 28601 X(4) ID PREFIX TAG	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	ATE, ZIP CODE				
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'	V 536	Interview on 3/7/19 w -Had not received trairestrictive intervention Interview on 3/7/19 w revealed: -Will ensure Counseld alternatives to restrict possible; -Will ensure all new s alternatives to restrict	ith Counselor #25 revealed: ning in alternatives to a since starting at the facility. ith the Program Director or #25 receives training in ive intervention as soon as taff receive training in ive intervention prior to	V 536					

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