	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION		
AND FLAN	IDENTIFICATION NOWIDEN.		A. BUILDING: _		COMPLETED	
	MHL059-024				R 03/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MCLEOD	ADDICTIVE DISEASE CE	NTER - MARION	EST MEDICAL COU DN, NC 28752	JRT		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual, complaint and follow up survey was completed on 3/27/19. The complaints were unsubstantiated (intake # NC00145758 and #NC00148505). Deficiencies were cited.  This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment.					
	The census at the time	ne of the survey was 298.				
V 235	27G .3603 (A-C) Outp	ot. Opiod Tx Staff	V 235			
	10A NCAC 27G .3603 STAFF  (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment.  (b) Each facility shall have at least one staff member on duty trained in the following areas:  (1) drug abuse withdrawal symptoms; and  (2) symptoms of secondary complications to drug addiction.  (c) Each direct care staff member shall receive continuing education to include understanding of the following:  (1) nature of addiction;  (2) the withdrawal syndrome;  (3) group and family therapy; and  (4) infectious diseases including HIV, sexually transmitted diseases and TB.					

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

TITLE (X6) DATE

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	MHL059-024	B. WING		03	R 3/27/2019
ROVIDER OR SUPPLIER	1	DDRESS CITY STATE	ZIP CODE	, ,	
	117 WES				
ADDICTIVE DISEASE C	ENTER - MARION MARION	I, NC 28752			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From pag	ge 1	V 235			
Based on record revialled to maintain the counselor to each 50 Review on 3/26/19 of Practitioner" dated 3 -The caseload of Co-The caseload of Co-The caseload of Co-The caseload of Co-The caseload of "In Interview on 3/26/19 revealed: -She had 5 current of counselor positions: -No new clients were vacancies; -She was aware of to counselor to 50 clier caseloads exceeded requirement.  This deficiency constitutions and the counselor counselor to the counselor counselor to the counselor counselor to the counselor to the counselor couns	riew and interview, the facility of staffing ratio of one certified of clients. The findings are:  of the "Caseload By Attending 1/26/19 revealed: rounselor #2 was 60; rounselor #3 was 60; rounselor #4 was 60; rounselor #6 was 58; ractive Counselor" was 3.  with the Program Manager  counselors and 3 vacant that she was trying to fill; re being admitted due to these the required staffing ratio of 1 and the counselors' if the 1:50 staffing				
10A NCAC 27G .360 TREATMENT. OPEI (e) The State Autho	04 OUTPATIENT OPIOD RATIONS. rity shall base program	V 238			
	ROVIDER OR SUPPLIER  ADDICTIVE DISEASE OF SUMMARY SUMMARY SUBSECTION REGULATORY OF REVIEW ON 3/26/19 OF REVIEW ON 3/26/19 OF REVIEW OF REVIE	MHL059-024  ROVIDER OR SUPPLIER  ADDICTIVE DISEASE CENTER - MARION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the staffing ratio of one certified counselor to each 50 clients. The findings are:  Review on 3/26/19 of the "Caseload By Attending Practitioner" dated 3/26/19 revealed: -The caseload of Counselor #2 was 60; -The caseload of Counselor #4 was 60; -The caseload of Counselor #5 was 60; -The caseload of Counselor #6 was 58; -The caseload of "Inactive Counselor" was 3.  Interview on 3/26/19 with the Program Manager revealed: -She had 5 current counselors and 3 vacant counselor positions that she was trying to fill; -No new clients were being admitted due to these vacancies; -She was aware of the required staffing ratio of 1 counselor to 50 clients and the counselors' caseloads exceeded the 1:50 staffing	ROVIDER OR SUPPLIER  ADDICTIVE DISEASE CENTER - MARION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the staffing ratio of one certified counselor to each 50 clients. The findings are:  Review on 3/26/19 of the "Caseload By Attending Practitioner" dated 3/26/19 revealed: -The caseload of Counselor #2 was 60; -The caseload of Counselor #4 was 60; -The caseload of Counselor #5 was 60; -The caseload of Counselor #6 was 58; -The caseload of "Inactive Counselor" was 3.  Interview on 3/26/19 with the Program Manager revealed: -She had 5 current counselors and 3 vacant counselor positions that she was trying to fill; -No new clients were being admitted due to these vacancies; -She was aware of the required staffing ratio of 1 counselor to 50 clients and the counselors' caseloads exceeded the 1:50 staffing requirement.  This deficiency constitutes a recited deficiency and must be corrected within 30 days.  27G .3604 (E-K) Outpt. Opiod - Operations  V 238  10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  117 WEST MEDICAL COURT MARION, NC 28752  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED  COntinued From page 1  This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the staffing ratio of one certified counselor to each 50 clients. The findings are:  Review on 3/26/19 of the "Caseload By Attending Practitioner" dated 3/26/19 revealed: -The caseload of Counselor #3 was 60; -The caseload of Counselor #4 was 60; -The caseload of Counselor #4 was 60; -The caseload of Counselor #6 was 58; -The caseload of Counselor with the Program Manager revealed: -She had 5 current counselors and 3 vacant counselor positions that she was trying to fill; -No new clients were being admitted due to these vacancies; -She was aware of the required staffing ratio of 1 counselor to 50 clients and the counselors' caseloads exceeded the 1:50 staffing requirement.  This deficiency constitutes a recited deficiency and must be corrected within 30 days.  27G .3604 (E-K) Outpt. Opiod - Operations  V 238  10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS. (e) The State Authority shall base program	ROWIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  117 WEST MEDICAL COURT  MARION, NO 28752  SUMMARY STATEMENT OF DEPCISIONESS  (EACH DEPCISION) MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the staffing ratio of one certified counselor to each 50 clients. The findings are:  Review on 3/26/19 of the "Caseload By Attending Practitioner" dated 3/26/19 revealed:  The caseload of Counselor #2 was 60; -The caseload of Counselor #5 was 60; -The caseload of Counselor #5 was 60; -The caseload of Counselor #8 was 60; -The caseload of Timater was 58; -The caseload of Sounselor #0 was 58; -The caseload of Sounselor #0 was 58; -The caseload of Sounselor #0 was 58; -The caseload of Sounselor was 3. Interview on 3/26/19 with the Program Manager revealed: -She had 5 current counselors and 3 vacant counselor positions that she was trying to fill; -No new clients were being admitted due to these vacancies; -She was aware of the required staffing ratio of 1 counselor to 50 clients and the counselors' caseloads exceeded the 1:50 staffing requirement.  This deficiency constitutes a recited deficiency and must be corrected within 30 days.  27G .3604 (E-K) Outpt. Opiod - Operations  V 238  10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS.  (9) The State Authority shall base program

Division of Health Service Regulation

STATE FORM 6899 QTVB11 If continuation sheet 2 of 8

MHL059-024    MHL059-024   B WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  117 WEST MEDICAL COURT MARION, NC 28752  (X4-) ID (				_		D
MARION, NC 28752   NARION   NC 28752   NARION   NC 28752   NARION, N	MHL059-024			B. WING	<del></del>	
MARION, NC 28752   MARION   MARION   MARION, NC 28752   MARION   MARI	NAME OF PI	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE	
(A4) ID SUMMARY STATEMENT OF DEFICIENCIES PRETIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 2  law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.  (1) Levels of Eligibility are subject to the following conditions:  (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at	MCI EOD	ADDICTIVE DISEASE CE	NTED - MARION	EST MEDICAL CO	JRT	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 2  law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.  (1) Levels of Eligibility are subject to the following conditions:  (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at	WICLEOD	ADDICTIVE DISEASE CE	MARIO	ON, NC 28752		
law and regulations; (2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of two counseling session per month.  (1) Levels of Eligibility are subject to the following conditions:  (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	ULD BE COMPLETE
(2) compliance with all applicable standards of practice; (3) program structure for successful service delivery; and (4) impact on the delivery of opioid treatment services in the applicable population. (f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month.  (1) Levels of Eligibility are subject to the following conditions:  (A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at	V 238	Continued From page	2	V 238		
the clinic; (B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week; (C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of	V 238	law and regulations; (2) compliance standards of practice; (3) program strustervice delivery; and (4) impact on the treatment services in (f) Take-Home Eligible comprehensive mainterequests unsupervise methadone or other interestment of opioid active specified requirements treatment. The client requirements for contained must demonstrate the specified time per any level increase. In year of continuous treatment a minimum of month. After the first years of continuous treatment a minimum of month. (1) Levels of El following conditions: (A) Level 1. Du continuous treatment, limited to a single dos shall ingest all other of the clinic; (B) Level 2. After continuous program of granted for a maximuland shall ingest all othat the clinic each week (C) Level 3. After the services and shall of the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services are services and shall ingest all othat the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services and shall ingest all othat the clinic each week (C) Level 3. After the services and services are services and services and services and services are services and services and services and services and services are services and services and services and services and services and services are services and services a	with all applicable cucture for successful  me delivery of opioid the applicable population.  ility. Any client in tenance treatment who do rake-home use of medications approved for diction must meet the ts for time in continuous must also meet all the inuous program compliance the such compliance during riods immediately preceding the addition, during the first two counseling sessions per year and in all subsequent treatment a patient must treatment a patient must one counseling session per igibility are subject to the  ring the first 90 days of the take-home supply is the each week and the client doses under supervision at the a minimum of 90 days of compliance, a client may be m of three take-home doses ther doses under supervision tek; ther 180 days of continuous	V 238		

Division of Health Service Regulation

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL059-024	B. WING		R 03/27/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
MCI EOD	ADDICTIVE DISEASE CE	INTER - MARION 117 WES	T MEDICAL COUR	RT	
WICECOD	ADDICTIVE DISEASE CE	MARION	, NC 28752		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE COMPLETE
V 238	take-home doses and under supervision at the (D) Level 4. Aft treatment and a minimal continuous program of client may be granted take-home doses and under supervision at the (E) Level 5. Aft treatment and a minimal continuous program of granted for a maximuland shall ingest at leasupervision at the clin (F) Level 6. Aft treatment and a minimal continuous program of client may be granted take-home doses and dose under supervision days; and (G) Level 7. Aft treatment and a minimal continuous program of granted for a maximuland shall ingest at leasupervision at the clin (2) Criteria for Find Reinstatement of Take (A) A client who tests possibility (B) A client who screens within the sail all take-home eligibility (B) A client who screens within the sail all take-home eligibility	for a maximum of four I shall ingest all other doses the clinic each week; er 270 days of continuous num of 90 days of compliance at level 3, a for a maximum of five I shall ingest all other doses the clinic each week; ter 364 days of continuous num of 180 days of compliance, a client may be more fix take-home doses ast one dose under the each week; ter two years of continuous num of one year of compliance at level 5, a for a maximum of 13 I shall ingest at least one on at the clinic every 14 therefore years of compliance, a client may be more fixed to the continuous num of three years of compliance, a client may be more 30 take-home doses ast one dose under the continuous num of three years of compliance, a client may be more 30 take-home doses ast one dose under the continuous num of three years of compliance, a client may be more 30 take-home doses ast one dose under the continuous num of three years of compliance, a client may be more fixed to the continuous num of three years of compliance, a client may be more stored to the continuous num of three years of compliance, a client may be more stored to the continuous num of three years of continuous num of three years	V 238		

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PRINTED: 04/03/2019 FORM APPROVED

Division of Health Service Regulation

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
						R
		MHL059-024	B. WING		l l	/27/2019
NAME OF PE	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	TE. ZIP CODE		
			EST MEDICAL CO			
MCLEOD	ADDICTIVE DISEASE CE	ENTER - MARION	ON, NC 28752			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT	ION SHOULD BE	COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENCE		DATE
				DEI IOIEITO		
V 238	Continued From page	e 4	V 238			
	eligibility shall be dete	ermined by each Outpatient				
	Opioid Treatment Pro					
	=	to Take-Home Eligibility:				
		ne first two years of				
	` '	who is unable to conform to				
	the applicable manda	atory schedule because of				
	exceptional circumsta	ances such as illness,				
	-	sis, travel or other hardship				
	may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week					
		t two years of continuous				
	treatment.	two years or continuous				
		o is unable to conform to the				
	` '	schedule because of a				
		sability may be permitted				
		eligibility by the State				
	authority. Clients wh	o are granted additional				
	take-home eligibility of	due to a verifiable physical				
	disability may be gran	nted up to a maximum				
	30-day supply of take-home medication and shall					
	make monthly clinic v					
		Dosages For Holidays:				
	•	of methadone or other				
		d for the treatment of opioid thorized by the facility				
		idual client basis according				
	to the following:	idadi olioni baolo according				
	•	al one-day supply of				
		medications approved for the				
		ddiction may be dispensed				
		(regardless of time in				
	treatment) for each s	tate holiday.				
	` '	an a three-day supply of				
		medications approved for the				
	treatment of opioid ac	ddiction may be dispensed				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL059-024	B. WING		03/27/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		117 WES	MEDICAL COL	JRT	
MCLEOD	ADDICTIVE DISEASE CE	ENTER - MARION	NC 28752		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
			+	,	
V 238	Continued From page	e 5	V 238		
	to any eligible client b	pecause of holidays. This			
		oply to clients who are			
	-	medications at Level 4 or			
	above.				
		Medications For Use In			
		ne risks and benefits of			
		nadone or other medications			
	• •	pioid treatment shall be			
	discussed with each client at the initiation of treatment and annually thereafter.  (h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous				
	treatment. Additional	lly, in two out of each			
		f a client's continuous			
	-	least one random drug test			
		rogram staff. Drug testing is			
	to include at least the	- ·			
	methadone, cocaine,	, benzodiazepines and			
		ng results can be gathered			
	by either urinalysis, b	•			
	alternate scientifically	-			
	_	Restrictions. No client shall			
	•	ne facility while physically			
		hadone or other medications			
		pioid treatment unless the			
	-	opportunity to detoxify from			
	the drug.	Provention All licensed			
		Prevention. All licensed iction treatment facilities			
	which dispense Meth				
		ethadol (LAAM) or any other			
		nt approved by the Food and			
		or the treatment of opioid			
		to November 1, 1998, are			
		e in a computerized Central			
	Registry or ensure the	at clients are not dually			

Division of Health Service Regulation

STATE FORM 6899 QTVB11 If continuation sheet 6 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	MIII 070 004		B. WING		R	
		MHL059-024			03/27/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MCLEOD	ADDICTIVE DISEASE CE	ENTER - MARION	MEDICAL COL	JRT		
		MARION,	NC 28752			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 238	Continued From page	e 6	V 238			
V 230	enrolled by means of exchange with all opi within at least a 75-m program. Programs a participate in a comp Management and Wa System as established State Authority for Opicid Treatment Programed to establish control plan as part of shall document the procedures. A diversity the following element (1) dual enroll of that consist of client of program contacts, paregistry or list exchance (2) call-in's for or solid dosage form (3) call-in's for (4) drug testing review of the levels of medications approver addiction; (5) client attentions.	direct contact or a list oid treatment programs alle radius of the admitting are also required to atterized Capacity aiting List Management and by the North Carolina bioid Treatment.  Plan. Outpatient Addiction agrams in North Carolina are and maintain a diversion of program operations and an in their policies and alian in their policies and alian in their policies and alian in the central ages; bottle checks, bottle returns call-in's; drug testing; a results that include a of methadone or other d for the treatment of opioid dance minimums; and to ensure that clients	V 230			
	failed to ensure each	ew and interview the facility client attended the required each month for 1of 16				

Division of Health Service Regulation

STATE FORM 6899 QTVB11 If continuation sheet 7 of 8

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  117 WEST MEDICAL COURT MARION, NC 28752  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 7  Review on 3/26/19 of the record for Client #5 revealed: -Admission date of 3/7/16 with diagnoses of Severe Opioid Use Disorder and Hepatitis CMedical staffing on 1/4/19 which included the physician with the recommendation to increase counseling to 2 times each weekCounseling sessions were not increased until 1/28/19.  Interview on 3/27/19 with the Director revealed: -The counselor who was working with Client #5 was no longer employed at the clinic.	STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  117 WEST MEDICAL COURT MARION, NC 28752  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 238  Continued From page 7  Review on 3/26/19 of the record for Client #5 revealed: -Admission date of 3/7/16 with diagnoses of Severe Opioid Use Disorder and Hepatitis CMedical staffing on 1/4/19 which included the physician with the recommendation to increase counseling to 2 times each weekCounseling sessions were not increased until 1/28/19.  Interview on 3/27/19 with the Director revealed: -The counselor who was working with Client #5 was no longer employed at the clinic.							R
MCLEOD ADDICTIVE DISEASE CENTER - MARION    MARION, NC 28752			MHL059-024	B. WING		03	
MARION, NC 28752    (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (X5) (COMPLET TAG)	NAME OF PROVIDE	IDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
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Division of Health Service Regulation

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