Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.13 . 2.1.1				A. BUILDING: _				
		MHL0601206		B. WING		R 04/08/20	119	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MCLEOD	ADDICTIVE DISEASE CE	ENTER-4TH FLOOR		ON ROAD, 4T	H FLOOR			
			CHARLOT	TE, 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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE CO	(X5) DMPLETE DATE	
V 000	INITIAL COMMENTS			V 000				
	An annual and follow up survey was completed on 4-8-19. Deficiencies were cited.		eted					
	This facility is licensed for the following service category: 10A NCAC 27G 3400 Residential		ice					
	Treatment/Habilitation		. 070					
		sorders and 10A NCAC edical Detoxification for						
	Individuals Who are S							
V 736	27G .0303(c) Facility	and Grounds Maintena	ance	V 736				
		EMENTS	-					
		n and interviews the faced in a clean, safe, attra						
	revealed: -Room 434: patch had paint peeling, bar -Room 435: Bath	9 at approximately 2:00 th of wall near the show throom light buzzing. proom light was not won the peeling off the door, l	ver rking.					
	towel holder, bathroo	m light dim, what appe ed instead of a shower	ared					
	curtain.							
	-Room 432: Ligh the wall, carpet was t	t switch was smashed	into					
		was not working, tarp						

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601206		B. WING		04/0	R 8/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE	•		
MCI EOD	ADDICTIVE DISEASE C	ENTED ATU ELOOP	515 CLANT	ON ROAD, 4T	H FLOOR			
WICLEOD	ADDICTIVE DISEASE CE	ENTER-4TH FLOOR	CHARLOTT	E, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TIVE ACTION SHOULD BE COMP CED TO THE APPROPRIATE DA		
V 736	36 Continued From page 1			V 736				
	-Room 428: Sho the wall, paint on doo -Common room -Room 417: Ove	carpet. ling paint on the door. wer curtain rod coming o						
	Interview on 4-8-19 with the Quality Assurance/Quality Improvement Director revealed: -They had regular safety walk through'sThey had a full time maintenance manShe didn't understand why some of these problems weren't taken care of during the preventative steps that they had in placeThe situation would be addressed immediately.		se					
V 752	EQUIPMENT (b) Safety: Each faci constructed and equi ensures the physical visitors. (4) In areas of exposed to hot water	Water Temperatures 4 FACILITY DESIGN AN lity shall be designed, pped in a manner that safety of clients, staff ar the facility where clients the temperature of the ained between 100-116	nd	V 752				
	failed to ensure that I	as evidenced by: ns and interviews the faction of water was maintained address in areas that	- 1					

Division of Health Service Regulation

STATE FORM 6899 N55711 If continuation sheet 2 of 3

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601206		B. WING		l l	R 08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
MCLEOD	ADDICTIVE DISEASE CE	ENTER-4TH FLOOR		ON ROAD, 4T E, NC 28217	H FLOOR		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETE DATE	
V 752	REGULATORY OR LSC IDENTIFYING INFORMATION)		V 752				

Division of Health Service Regulation

STATE FORM 6899 N55711 If continuation sheet 3 of 3