PRINTED: 04/01/2019
FORM APPROVED

Division of Health Service Regulation

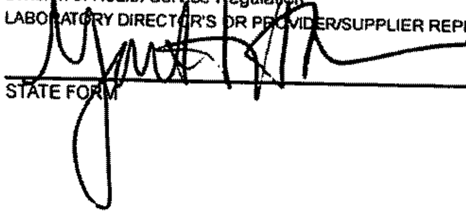
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl060-959	A. BUILDING: ______ B. WING ______	R 03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON 1	4508 CARRIAGE DRIVE CIRCLE CHARLOTTE, NC 28205

(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
V 000	INITIAL COMMENTS An annual and follow up survey was completed on 3-20-19. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G 1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117	Echelon Care's Admin. Team will follow-up with Facility Leadership and staff and reiterate the medication requirements for all facilities. Additionally, the Training Team will contact the Agency's Nurse and request a Medication Administration Training Course (refresher) and will send out refresher tools to the facilities. Echelon Care will continue to work closely with the pharmacy we use to ensure requirements are met.	4/15/19 & ongoing

Division of Health Service Regulation

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



TITLE: Operations Director

(X6) DATE: 4/15/2019

STATE FORM 6899 C15Y11 If continuation sheet 1 of 2

RECEIVED
By DHSR-Mental Health Licensure at 11:34 am, Apr 16, 2019

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V 117	Continued From page 1 This Rule is not met as evidenced by: Based on record review, interview and observation the facility failed to ensure that each prescription medication had a pharmacy packaging label affecting 1 of 3 audited clients (client #1). The findings are: Review on 3/4/19 of client #1's record revealed: -Admission date of 8/10/18; -Diagnoses of Attention Deficit Hyperactivity Disorder Combined Type, Oppositional Defiant Disorder and Adjustment Disorder; -Physician order dated 2-13-19 for Magnesium Oxide 400mg 2 tablets by mouth daily. Interview on 3/4/19 with the staff #1 revealed: -The label for the medication Magnesium Oxide was ripped off after a liquid spilled on the bubble pack, thereafter he obtained a new bubble pack, took the medications out of the old bubble pack and placed them in the new bubble pack, however the new bubble pack label was blank and did not have the administration instructions. Observation on 3/4/19 at approximately 5:00pm of client #1's medication revealed: -Bubble pack for Magnesium Oxide 400mg with no with no pharmacy label identifying name of client, prescriber's name, dispensing date, directions for administration, name of the dispensing practitioner, and name, address and phone number of the pharmacy.	V 117		

11:21 04/16/19 ET Pg 2-5

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 8, 2019

Alex Wright, CEO
Echelon Consulting, Inc.
7209J East W.T. Harris Blvd. Suite 207
Charlotte, NC 28227

Re: Annual and Follow up Survey completed 3-20-19
Echelon 1, 4508 Carriage Drive Circle, Charlotte, NC 28205
MHL # 060-959
E-mail Address: awright@echeloncare.com

Dear Mr. Chambliss:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed 3-20-19.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within <u>ten days of receipt of this letter.</u> Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is May 19, 2019.

What to Include in the Plan of Correction

Fm:Martine' To:Danalouise Reeves Administrative Specialist 1

Fm:Martine' To:Danalouise Reeves Administrative Specialist 1 11:21 04/16/19 ET Pg 3-5

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

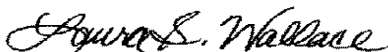
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at (704) 596-4072.

Sincerely,



Laura S. Wallace, MA
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
QM@partnersbhm.org

Fax

To:	Danalouise Reeves Administrative Specialist 1	**From:**	Martine' Chambliss
Fax:	19197158078	**Pages:**	5
Re:	Echelon 1- MHL-060-959, 3-20-2019 POC	**Date:**	Apr 16, 2019

Urgent **X** **For Review** **Please Comment** **Please Reply** **For Information**

- **Comments:**

Ms. Reeves:

Please see the attached completed POC for the above referenced. Please let me know if there is anything else that is needed from us. Thanks.

Mr. Martine' Chambliss

704.594.9119