

**Deficiency:** Releases being completed but no COC (coordination of care) requested from these releases: The issue identified with the patient's #11 and #13 was that clinical staff completed a release of information for the providers but these releases were never printed off and given to the appropriate staff to request records for coordination of care.

**Plan of correction:** Whenever a release is completed by clinical staff, where medication might not be involved, the counselor will create a care plan 1 month out to verify that the release was sent and identify if records were received back.

**Deficiency:** No COC with medications prescribed with the correlated medical provider: Patient #8 had been given medications with no COC follow up regarding these medications with the medical provider.

**Plan of correction:** When medications are brought in for review, nursing staff will bring the patient into a counselor's office. While the nurse documents all the medications, the counselor will create releases, with the patient's consent, for all prescribing providers identified. A care plan will then be created 1 month out to verify that the release was sent and identify if records were received back.

**Deficiency:** Counselor caseloads did not meet required ratio of 1 counselor to 50 patients. Counselor caseloads were all above 50 and the program manager was also carrying a caseload.

**Plan of correction:** While being short staffed, the program is not currently accepting new patients. Program manager has been actively seeking clinicians. A new clinician is hired to start January 6, 2020. This will assist in getting caseloads back to 50. This will leave 1 open vacancy for a counselor position. Program manager will continue to interview applicants in attempt at filling this vacancy. Upon becoming fully staffed, the program manager will relieve her caseload and admission will be re-opened.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL014-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>MCLEOD ADDICTIVE DISEASE CENTER-LENOIR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 MORGANTON BOULEVARD LENOIR, NC 28645</b>
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on 11/27/19. Deficiencies were cited. The annual census at the time of the survey was 336.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p>	V 000		
V 233	<p>27G .3601 Outpt. Opiod Tx. - Scope</p> <p>10A NCAC 27G .3601 SCOPE</p> <p>(a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services.</p> <p>(b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual.</p> <p>(c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days.</p> <p>(d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels.</p>	V 233		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL014-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>MCLEOD ADDICTIVE DISEASE CENTER-LENOIR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 MORGANTON BOULEVARD LENOIR, NC 28645</b>
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 233	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on interviews and record review the facility failed to provide services designed to affect constructive changes in the client's lifestyle by using methadone in conjunction with the provision of rehabilitation and medical services affecting 3 of 17 sampled clients (#8, #11, #13). The findings are:</p> <p>Record review on 11/26/19 for Client #8 revealed: -Admitted on 5/27/15 with diagnosis of Opioid Use Disorder. -Medication record indicated that Client #8 was prescribed Atenolol 25mg, daily. It further indicated that coordination of care was needed with the prescriber. -No evidence in the record that the coordination of care was completed with the physician who prescribed the Atenolol.</p> <p>Record review on 11/26/19 for Client #11 revealed: -Admitted on 3/27/19 with diagnosis of Opioid Use Disorder, Bi Polar Disorder and Depression. -Medication record indicated that Client #11 took Latuda daily and Clonidine three times daily. -The record further indicated that Client #11 had changed mental health providers. -A release of information had been signed on 6/21/19 by Client #11 for the facility to coordinate care with other medical providers. -No evidence in the record that the coordination of care was completed with the physician who prescribed the psychotropic medications for Client #11.</p> <p>Record review on 11/26/19 for Client #13 revealed:</p>	V 233		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL014-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>MCLEOD ADDICTIVE DISEASE CENTER-LENOIR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 MORGANTON BOULEVARD LENOIR, NC 28645</b>
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 233	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-Admitted on 1/15/19 with diagnosis of Opioid Use Disorder.</li> <li>-Medication record indicated that Client #13 took Chantix twice daily.</li> <li>-A release of information had been signed on 1/15/19 by Client #13 for the facility to coordinate care with other medical providers.</li> <li>-No evidence in the record that the coordination of care was completed with the physician who prescribed the medication for Client #13.</li> </ul> <p>Interview on 11/27/19 with the Program Manager revealed:</p> <ul style="list-style-type: none"> <li>-Both Clients #11 and #13 had signed a release of information but there was no coordination of care completed with the physician's who prescribed their medications.</li> <li>-It was the facilities responsibility to verify any medications that a client was prescribed.</li> <li>-She would sometimes review physician notes to determine any coordination of care that was needed.</li> <li>-She acknowledged that physician note about the medication for Client #8 and indicated that coordination of care should have been the next step.</li> <li>-The lack of coordination of care for these clients was an oversight and she indicated that she would immediately address the problem.</li> </ul>	V 233		
V 235	<p>27G .3603 (A-C) Outpt. Opiod Tx. - Staff</p> <p>10A NCAC 27G .3603 STAFF</p> <p>(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</p>	V 235		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL014-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>MCLEOD ADDICTIVE DISEASE CENTER-LENOIR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 MORGANTON BOULEVARD LENOIR, NC 28645</b>
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 235	<p>Continued From page 3</p> <p>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.</p> <p>(b) Each facility shall have at least one staff member on duty trained in the following areas:</p> <ol style="list-style-type: none"> <li>(1) drug abuse withdrawal symptoms; and</li> <li>(2) symptoms of secondary complications to drug addiction.</li> </ol> <p>(c) Each direct care staff member shall receive continuing education to include understanding of the following:</p> <ol style="list-style-type: none"> <li>(1) nature of addiction;</li> <li>(2) the withdrawal syndrome;</li> <li>(3) group and family therapy; and</li> <li>(4) infectious diseases including HIV, sexually transmitted diseases and TB.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to meet the minimum staffing ratio of 1 counselor to 50 clients. The findings are:</p> <p>Review on 11/25/19 of a written facility client list dated 11/25/19 revealed:</p> <ul style="list-style-type: none"> <li>-The written client list had the total client caseload count for each counselor;</li> <li>-Counselor #1's caseload was 59;</li> <li>-Counselor #2's caseload was 56;</li> <li>-Counselor #3's caseload was 59;</li> <li>-Counselor #4's caseload was 57;</li> <li>-Counselor #5's caseload was 56;</li> <li>-The Program Manager's caseload was 40;</li> <li>-The remainder of clients were indicated in an "inactive counselor" list.</li> </ul>	V 235		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL014-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2019</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>MCLEOD ADDICTIVE DISEASE CENTER-LENOIR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>222 MORGANTON BOULEVARD LENOIR, NC 28645</b>
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 235	<p>Continued From page 4</p> <p>Interview on 11/26/19 with Counselor #4 revealed: -Due to 2 vacant counselor positions, her caseload was approximately 55 clients.</p> <p>Interview on 11/26/19 with Counselor #1 revealed: -Her client caseload exceeded 50 clients.</p> <p>Interviews on 11/25/19 and 11/27/19 with the Program Manager revealed: -She acknowledged on both these dates that she was aware the facility was out of compliance with the minimum staffing ratio of 1 counselor to 50 clients; -She was helping with the client counseling caseload due to 2 vacant counselor positions; -The facility was in the process of trying to fill the vacant positions.</p>	V 235		



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

December 18, 2019

Ayanna Pressley, Director of Quality Improvement  
McLeod Addictive Disease Center, Inc.  
515 Clanton Road  
Charlotte, NC 28217

Re: Annual Survey completed November 27, 2019  
McLeod Addictive Disease Center-Lenoir, 222 Morganton Boulevard,  
Lenoir, NC 28645  
MHL # 014-083  
E-mail Address: Ayanna.pressley@mcleodcenter.com

Dear Ms. Pressley:

Thank you for the cooperation and courtesy extended during the annual survey completed November 27, 2019.

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 ten days of receipt of this letter. 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**

Standard level deficiencies are cited for:

- 10A NCAC 27G. 3601 Scope of Outpatient Opioid Treatment (V233);
- 10A NCAC 27G .3603 Staff (V235).

### **Time Frames for Compliance**

Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is January 26, 2020.

### **What to include in the Plan of Correction**

- 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.).

#### **MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

#### **NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

December 18, 2019

Ayanna Pressley

McLeod Addictive Disease Center, Inc.

- 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.

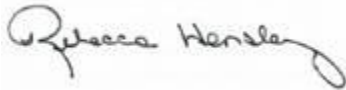
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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 Sonia Eldridge, Mountains Team Leader, at (828) 665-9911.

Sincerely,



Rebecca Hensley  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Enclosure

Cc: qmemail@cardinalinnovations.org  
DHSR@Alliancebhc.org  
QM@partnersbhm.org  
dhhs@vayahealth.com  
DHSRreports@eastpointe.net  
\_DHSR\_Letters@sandhillscenter.org  
Leza Wainwright, Director, Trillium Health Resources LME/MCO  
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO  
Smith Worth, SOTA Director