STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-100	A. BUILDING: _____ B. WING _____	R 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEOD ADDICTIVE DISEASE CENTER	549 COX ROAD GASTONIA, NC 28054

(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, complaint and follow-up survey was completed on 9/28/21. The complaints were unsubstantiated(Intakes #NC180066 and #NC177112). Deficiences were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program(SAIOP). Census: 345	V 000	DHSR - Mental Health OCT 28 2021 Lic. & Cert. Section	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the	V 367		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director of Compliance | 10/24/2021

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V 367	Continued From page 1 cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall	V 367		

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V 367	Continued From page 2 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all level II incidents that occur during the provision of billable services were reported to the LME responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 9/23/21 of the Level I incident reports from 6/1/21 to 9/23/21 revealed: -incident reports dated 6/10/21 regarding client #15 documented the facility called 911 and EMS responded for a medical issue for client #15; -incident report dated 6/23/21 regarding client #15 documented the facility called 911 and EMS	V 367		

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V 367	Continued From page 3 responded for a medical issue for client #15; -incident report dated 6/24/21 regarding client #14 documented the facility called 911 and EMS responded for a medical issue for client #14. Interview on 9/24/21 with client #14 revealed: -wasn't feeling good; -EMS came and took her to the hospital; -felt like she was fainting. Interview on 9/24/21 with client #15 revealed: -he fell; -EMS was called. Interview on 9/24/21 with staff #3 revealed: -called EMS because client #15 came walking into the facility and reported he fell and hit his head; -noticed he was delirious; -he had blood on his head; -had a huge gash; -another time client #15 had a seizure in a staff's office; -called EMS again for client #15. Review on 9/23/21 revealed no Level II incident reports in IRIS(NC Incident Response Improvement System) for the above listed incidents regarding client #14 and client #15.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 4 (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with	V 536		

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V 536	Continued From page 5 disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the	V 536		

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V 536	Continued From page 6 service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or	V 536		

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V 536	Continued From page 7 train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure prior to providing services to people with disabilities, staff demonstrated competence by successfully completing training in alternatives to restrictive interventions and failed to ensure staff completed annual formal refresher training for 3 of 3 staff(#1, #2 and #3) and 1 of 1 Dosing Nurse. The findings are: Review on 9/27/21 and 9/28/21 of staff personnel records revealed: -staff #1 was hired on 11/18/19 with the job title of clinician and there was documentation of completed training in CPI(Nonviolent Crisis Intervention) dated 7/22/19 with an expiration date of 7/31/20. No documentation of completed updated training in CPI was present in the record; -staff #2 was hired on 7/19/21 with the job title of clinician and no documentation of completed training in alternatives to restrictive intervention was present in the record; -staff #3 was hired on 3/16/20 with the job title of clinician and no documentation of completed training in restrictive interventions was present in the record; -the Dosing Nurse was hired on 5/7/08 and there was documentation of completed training in CPI dated 2/23/20 with an expiration date of 2/28/21.	V 536		

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V 536	Continued From page 8 No documentation of completed updated training in CPI was present in the record. Interview on 9/27/21 with staff #1 revealed: -been here 2 years; -not had training in NCI(North Carolina Interventions) yet; -had NCI "outside of here." Interview on 9/24/21 with staff #2 revealed: -been here 2 months; -have a caseload of 46 clients; -not had CPI training yet. Interview on 9/24/21 with staff #3 revealed: -been here almost 2 years; -got NCI in the beginning; -don't really remember. Review on 9/27/21 of an email sent from the Director of Compliance and Quality Improvement revealed: -consider CPI and NCI the same; -staff do not have the training in CPI/NCI yet; -confirmed this information with the HR(Human Resources) Director; -the HR Director was in the process of scheduling the training for the staff and will ensure it is completed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly	V 736		

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V 736	Continued From page 9 manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 9/23/21 at 11:00 am revealed: -waiting room had one broken blind; -bathroom #1: soap dispenser disabled, and soap was gone. Torn wallpaper over urinal approximately 6 by 2 inches; -office on the far side of the building has wrinkled carpet(possible trip hazard); -bathroom #2: obscene profanity written on above the sink, small area of torn wallpaper approximately 3-4 inches; -drug screen bathroom trashcan was full and the walls under the soap dispenser were dirty; -multiple cigarette butts on the ground in the front entrance area of the facility; -parking lot: litter including one discarded mask, what appears to be a sanitary napkin in the back of the parking lot and one soda can. Interview on 9/23/21 with client #6 revealed: -trash situation "getting overflow;" -"it don't look good we are right on the highway." Interview on 9/24/21 with client #10 revealed: -"the bathrooms is horrible;" -"there is either no soap or toilet paper or both;" -there is trash they should clean it out sometimes."	V 736		

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V 736	Continued From page 10 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		

Citation	Correction due date	Corrections and Action to Prevent	Owner	Follow up	Frequency
Incident reporting requirements (10A NCAC 27G.0604)	11/27/2021	Restrospective review of IR to perform LME notification for any missed. Review IR regulations with Compliance team; Including mock scenarios to ensure staff recognize difference between levels for accurate/timely reporting	QI	A weekly review of Incident Reports will be performed to ensure all reports are coded to the appropriate level	weekly
Training on alternatives to restrictive interventions (10A NCAC 27E.0107)	10/27/2021	Due to a staffing shortage McLeod only has 1 certified trainer. We are committed to getting staff trained and up to date. In order to do so we will have to push out our correction to 11/15/21. Staff identified as having missing or late training will have their training completed by 11/15/2021. A formalized process to ensure all staff receive their training timely (before working with patients and at their annual due date) will be created and implemented	HR	HR Director will hold monthly meetings to review and ensure all training is up to date.	monthly
Facilities and Grounds Maintenance (10A NCAC 27G.0303)	10/27/2021	Identified areas of facility have been addressed. Facility Program Manager will ensure cleaning staff are addressing all areas of the facility.	MAT	Program Manager or designee will perform spot checks of facility and grounds to ensure facility is appropriately maintained	weekly