Jessie Alexander 7/13/18
Executive Director

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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
	MHL045-133	A. BUILDING: _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

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V 000	INITIAL COMMENTS A complaint survey was completed on June 14, 2018. The complaint was substantiated (Intake #NC00139457). Deficiencies were cited. This faciity is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	V 000	DHSR - Mental Health JUL 18 2018 Lic. & Cert. Section	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious	V 108		

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V 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure staff were trained to meet the treatment needs of the clients and failed to ensure that a staff member who was trained in first aid and CPR (cardiopulmonary resuscitation) was available at all times when clients were present in the facility effecting 4 of 4 audited staff (Staff #1, the House Manager, Therapist/QP, and Behavioral Technician Supervisor). The findings are: Review on 6/11/18 of the personnel record for the Regional Behavioral Technician Supervisor revealed: -Hired 4/30/18. -No documentation of First Aid and CPR training. -No documentation of training in the specific identified treatment needs of the clients served to include their eating disorders, and goals of treatment. Documentation for Eating Disorders was "Eating Disorder Behaviors to be aware of" dated 5/11/18. No documentation of training in Anorexia Nervosa or Bulimia. -Document signed by this staff member that she had been trained in Bi Polar Disorder, Anxiety Disorder, Depression, Obsessive Compulsive Disorder, and PTSD (post-traumatic stress disorder) on 5/11/18. Review on 6/7/18 of the personnel record for the House Manager revealed: -Hired 5/11/18.	V 108		

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V 108	Continued From page 2 -Documentation for First Aid and CPR training completed 6/6/18 indicated "Online Training". -No documentation of training in the specific identified treatment needs of the clients served. Documentation for Eating Disorders was "Eating Disorder Behaviors to be aware of" dated 5/11/18. No documentation of training in Anorexia Nervosa or Bulimia. -Document signed by this staff member that she had been trained in Bi Polar Disorder, Anxiety Disorder, Depression, Obsessive Compulsive Disorder, and PTSD (post-traumatic stress disorder) on 5/11/18. Review on 6/6/18 and 6/7/18 of the personnel record for Staff #1 revealed: -Hired 5/15/18. -Documentation for First Aid and CPR training completed 6/6/18 indicated "Online Training". -No documentation of training in the specific identified treatment needs of the clients served to include their mental health needs and goals of treatment. Documentation for Eating Disorders was "Eating Disorder Behaviors to be aware of" dated 5/11/18. No documentation of training in Anorexia Nervosa or Bulimia. -Document signed by this staff member that she had been trained in Bi Polar Disorder, Anxiety Disorder, Depression, Obsessive Compulsive Disorder, and PTSD (post-traumatic stress disorder) on 5/11/18. Review on 6/11/18 of the personnel record for the Therapist/Qualified Professional (QP) revealed: -Hired 5/7/18. -No documentation of First Aid and CPR training. -No documentation of training in the specific identified treatment needs of the clients served to include their eating disorders, and goals of treatment. Documentation for Eating Disorders	V 108		

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V 108	Continued From page 3 was "Eating Disorder Behaviors to be aware of" dated 5/11/18. No documentation of training in Anorexia Nervosa or Bulimia. -No training documented in the mental health needs of clients. Interviews on 6/6/18, 6/11/18 and 6/12/18 with the House Manager revealed: -She had received training on 5/15/18 and worked on 5/16/18. -"We learned as we went." -She indicated that her training (conducted on 5/15/18 and was for all staff, including Staff #1) included reading trauma informed care information and that "it touched a little on mental health disorders". She indicated that this training was very brief. -She was never told about the definitions of bulimia and anorexia. -It was "learn as you go" and was told "if you don't know something ask". -She stated that they were told that the clients would want to purge and would have a depressed mood. "That was about it." -She stated that the training was not extensive and "most staff don't know what to do". -"Everybody is kind of lost." Interview on 6/12/18 with the Site Coordinator revealed: -Staff were hired at the last minute to open. Staff started working right away. -"Training was done on the fly." Interview on 6/7/18 with Staff #1 revealed: -She knew that Former Client #3 (FC #2) had been in a state hospital and knew that it was for mental health treatment. She stated that she knew that FC #3 had "issues going on and had done some self-harm".	V 108		

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V 108	Continued From page 4 Interviews on 6/7/18 and 6/11/18 with the Therapist/QP for FC #3 revealed: -She began working at the facility on 5/7/18 as a therapist. -She received 1 day of orientation and some training on the electronic record. Interviews on 6/5/18 and 6/12/18 with the Supervisor for the Behavioral Technicians revealed: -All of the First Aid and CPR (cardiopulmonary resuscitation) was conducted on line. -Staff were trained on the self-harm protocol, trauma informed care, and eating disorder behaviors to watch for. In treatment teams they discussed the treatment goals for each client. Staff had also shadowed with her for training. Only certain staff were trained in medications. -There was no documentation to indicate training specific to Anorexia, Bulimia, or Mental Illness Disorders. Later during the course of the survey she indicated that the "Trauma Informed Care" training piece covered all of the mental health disorders. Interviews on 6/5/18, 6/7/18 and 6/12/18 with the Executive Director/RN (Registered Nurse) revealed: -The Behavioral Technician Supervisor was responsible for ensuring that training had been completed. -The Human Resource department should have sent a list about any training due to be completed. -The former Clinical Director had trained all clinical staff, however, the documentation of that training had disappeared. -She thought that on-line training was acceptable for staff to be recertified in first aid and CPR. -Their Orientation training covered trauma	V 108		

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V 108	Continued From page 5 specific training that included PTSD (post-traumatic stress disorder), Anxiety Disorder, Depression, and Eating Disorders. -She indicated that she thought every staff had received client specific training. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	V 109		

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V 109	Continued From page 6 develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review, and interview the facility failed to ensure that 1 of 1 audited Therapist/Qualified Professionals (Therapist/QP) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 6/11/18 of the personnel record for the Therapist/Qualified Professional (QP) revealed: -Hired 5/7/18. -Master's Degree in Social Work from a University. -Current LCSW (Licensed Clinical Social Worker). -Experience in the field of Eating Disorders. Interviews on 6/7/18 and 6/11/18 with the Therapist/QP for Former Client #3 (FC #3) revealed: -The pre-admission assessment was completed by the call center. -As a therapist she was responsible for the Bio Psychosocial assessment within the first day and then the treatment plan within a week. She indicated that the treatment plan was based on assessment information and working with the patient on goals.	V 109		

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V 109	Continued From page 7 -She was aware of the incident when FC #3 had self-harmed by cutting her arm while in the PHP (partial hospitalization program) program. Following this incident FC #3 had remained in Broughton Hospital until her admission in the residential program. -Two staff from the PHP program had expressed concerns about FC #3 coming into the residential program. They had indicated to her that "[FC #3's] behavior is so erratic and impulsive" and that with one trigger she will go to an extreme consequence. -She indicated that the former Clinical Director "may have" brought information about FC #3 to everyone's attention. -She indicated that when FC #3 was placed she presented as having no current issues with suicidal ideation or self-harm. FC #3 expressed some hopeless thoughts but there was no indication she would harm herself. She did not believe FC #3 to be actively suicidal. -She received information from the previous hospitalization at the state psychiatric hospital. This information was used in the assessment process. -There was no safety contract for FC #3 but indicated that there "probably should have done one since she came out of the hospital." -She was required to meet with clients individually twice per week and one time per week with the family. She also was required to conduct group sessions. -She had met one time with FC #3 on 5/24/18 for an individual session. FC #3 had been in group sessions on 5/21/18, 5/22/18, 5/23/18 and a group session on 5/24/18. -She had identified the needs of FC #3 to be how to manage difficult emotions, how to address her mother about future planning, distress tolerance and mindfulness but did not develop goals or	V 109		

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V 109	Continued From page 8 strategies around these. -A scratch had been observed on FC #3's arm. She stated that FC #3 had eczema. She explored this with FC #3 and her mother. They discussed the use of a cream for eczema. They further discussed FC #3 wearing short sleeves and no sweatshirts. She had determined that FC #3 had a skin condition and that the scratch was not a result of self-harm. Interviews on 6/5/18, 6/7/18 and 6/12/18 with the Executive Director/RN (Registered Nurse) revealed: -She indicated that the person centered plan should have been completed and there should have been goals for this client. -She was unaware that the treatment plan was incomplete. Interview on 6/7/18 with the Program Director revealed: -Therapists were to meet with their clients 3 times per week, twice individually and one time with a family member. Group counseling was in addition to that. These sessions were monitored by the Clinical Director. She and the Executive Director were in the process of hiring a new Clinical Director. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN	V 111		

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V 111	Continued From page 9 (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan affecting 1 of 2 current clients (#1) and 2 of 2 former clients (FC #3, FC #4). The findings are:	V 111		

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V 111	Continued From page 10 Client 1: Record review on 6/5/18 for Client #1 revealed: -Admitted on 5/22/18 with diagnoses of Bulimia Nervosa, Major Depressive Disorder, Anxiety Disorder, and PTSD (post-traumatic stress disorder). -Age 16. -Pre-admission assessment 4/18/18 indicated in addition to her eating disorder issues a " ...history of self-harm, cutting, picking, scratching, burning, self-harm: current ...Client has been burning, picking and scratching herself for the last few years, the last time was 3 days ago ...Client did attempt to overdose on Melatonin x2 in 2017, and in 2016 cuts her wrists, and one time back in 2014 she tried to jump off a roof ..." -History of trauma-sexual and physical abuse. -Biopsychosocial assessment dated 4/19/18 indicated " ...Client is experiencing disrupted eating patterns presenting as a cycle of restriction, bingeing and purging. Client is also experiencing anxiety, depression, and symptoms of PTSD. Client reports self-harm and suicidal ideation that ranges from passive to active with previous attempts ...Inpatient-4x-3/4 were suicide attempts; first one due to intrusive thoughts and suicidal ideation; currently client reports ranging from passive to active SI (hoping to get in a car accident or voice in brain "step off into the road") ..." Review on 6/6/18 of the person centered plan dated 6/2/18 for Client #1 revealed: -This document listed a problem/goal/intervention for three problem areas of "Unipolar Depression, Eating Disorder, and Anxiety". This document was only signed by the therapist. -Goals were "Develop healthy interpersonal relationships that lead to alleviation of and help	V 111		

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V 111	Continued From page 11 prevent the relapse of depression symptoms; Elevate mood and show evidence of usual energy, activities and socialization level; Develop coping strategies to address emotional issues that could lead to relapse of the eating disorder; Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods; Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder; Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired; and Parents effectively manage child's anxious thoughts, feelings, and behaviors. -The Intervention for each goal was "Work with client on IFS (Internal Family Systems), DBT (Dialectical Behavior Therapy), FBT (Family Based Treatment)-informed therapy stages." No other strategies were documented for staff to utilize to address Client #1's mental health issues, self-harm or suicidal ideations/behaviors. Former Client #3 (FC #3): Record review on 6/5/18 for Former Client #3 (FC #3) revealed: -Admitted on 5/15/18 with diagnoses of Anorexia Nervosa, Bulimia Nervosa, Bi Polar Disorder, Post-Traumatic Stress Disorder (PTSD), Anxiety Disorder, Borderline Personality Disorder, and Disrupted Mood Dysregulation Disorder. -Discharged 5/24/18. -Age 16. -Pre-admission assessment dated 5/14/18 indicated " ...Mood: Depressed ...Judgement: Grossly impaired ...Trauma/Abuse History: Sexual and the client was 12 ...History of Self-Harm: Yes, cutting, picking, burning, scratching ...Self-Harm: Current ...Suicidal	V 111		

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V 111	Continued From page 12 Ideations or attempts: Yes, past ...Client has a history of self-harm and the last time was 3 mos ago, she does have a hx of SI (suicidal ideation) ...[hospital]-[out of state] in 2015-2017, [hospital]-Currently IP (inpatient) ..." -Psychiatric Evaluation dated 5/15/18 indicated " ...Nearly lifelong dysthymia with episodes of sustained major depression ...Sexually assaulted at the age of 12 and most psychiatric symptoms have been problematic since around that time. Anxiety does predate this, as the patient felt excluded by her peers in early childhood ...History of cutting behaviors, chronic, but not recently. History of 2-3 sincere suicide attempts and multiple threats/gestures. No sincere attempt in the past year ...Multiple hospitalizations, approximately 18, and as recently as this month (1/2018-5/2018 at [state hospital] ...mild increase in depressive symptoms over the past two weeks perhaps ..." -Bio Psychosocial Assessment dated 5/15/18 indicated " ...[FC #3] has experienced suicidal ideation in the past and has tried to take her life via overdose. She denies current SI (suicidal ideation) or self-harm urges. Pt (patient) is able to contract for safety ...pt was hospitalized at [state hospital] from 1/12/18-5/15/18 for cutting her arm ...[hospital]IP (inpatient)-2013- 3 days for self-harm, [mental health treatment center] 2013- 7 days for self-harm, [hospital psychiatric unit] IP 2014, 2015, 2017-one week each episode-self-harm and SI ...recommend 24 hour safety monitoring ..." Review on 6/11/18 of prior hospitalization information obtained by the facility for FC #3 revealed: -" ...[local hospital] Inpatient 11/22/2017-11/28/17 ...admitted to the adolescent unit ...symptoms associated with mood disorder including ongoing	V 111		

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V 111	Continued From page 13 anhedonia, hopeless helpless feelings and suicidal ideations. She has extensive history of mood lability ...She was hospitalized in an effort to evaluate and stabilize her moods and behaviors that are felt to place her at significant risk of harm ...history of regressive behaviors when in restrictive environments ...long history of suicide attempts ...long history of medication non-compliance and for hoarding medications and overdosing ...extensive history of self-injurious behaviors that includes cutting ...history of multiple psychotropic medication trials ..." -"[state hospital] Inpatient 1/12/18 ...[FC #3] was prompted to eat her lunch 3/11/18, when she refused to so and stomped out of the dining room. She was later found in her bed with a T-shirt tied around her neck. At that stage she was placed on safety precautions strict for suicide ...second admission to [state hospital] ...discharged from [state hospital] in 2015 to be placed in a PRTF (psychiatric residential treatment facility) ...after the [facility name] PRTF [FC #3] received inpatient psychiatric care at the [hospital] in [out of state] for 1-1/2 years. She was discharged from there in May 2017 with arrangements to receive intensive in-home services and partial hospitalization (through [licensee]) ...She is extremely knowledgeable of therapeutic techniques and interventions and is therefore excessively defensive. She is now demonstrating potential for sabotaging behaviors to influence placement ..." Review on 6/6/18 of the treatment plan for FC #3 revealed: -Treatment Plan dated 5/8/18 included one goal of "[FC #3] will transition successfully to [licensee] residential program for eating disorder specific treatment ..." No goals or strategies to address	V 111		

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self-injurious behaviors or suicidal ideation.
-Another treatment plan in her record was dated 5/29/18, five days after her discharge.
-There were no strategies documented in the record to address FC #3's presenting problems.

Review on 6/6/18 of progress notes for FC #3 revealed:
-"On 5/22/18 staff contacted on call supervisor to address scratches on client's (FC #3) arm ...Client reports that it is due to her dry skin (eczema) ...Supervisor asked client about self harm urges. Client stated that her urges were a 0 ..." Note dated 6/4/18.
-Treatment Team note dated 5/23/18 indicated "pt (patient) is aggravating her eczema on arm: team will ask pt to only wear short sleeves and stop wearing big sweatshirt. Pt is hiding food, and has been seen purging ...informed client she cannot wear sweatshirts at the table ...noticed scabs on the client's knuckles ..."
-Therapist note dated 5/24/18 indicated " ...pt was tearful in discussing how she 'feels stuck' ...this therapist asked pt if arm scratching was out of self harm urge or d/t (due to) itching and she reported it was itching. Pt agreed to continue practicing mindfulness to manage anxiety ..."
-Shift note dated 5/24/18 indicated "Other clients and I were headed downstairs to start night time snack and overnight awake remained outside the door with the door cracked as [FC #3] was using the bathroom. Overnight awake listened for the flush and her washing her hands, [FC #3] confirmed she was alright and overnight yelled for me (HM) (house manager) to notify me they were almost done and ready for snack. [FC #3] quietly locked the door and then overnight staff yelled down the stairs for me and I ran upstairs. Other client was present when this event occurred despite staff trying to separate. Once I was

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V 111	Continued From page 15 upstairs I attempted to get in the bathroom door. I asked [FC #3] to count for me, and she was not responding ...[FC #3] fainted and I was then able to get in the door. She had snuck a t-shirt in through her clothes and had tied it around her neck four times very tightly. I attempted to get the shirt from around her neck while her face was turning purple ...I asked for scissors, by the time she returned I had the shirt untied, tried to get [FC #3] to breathe, stood her up ...she started crying and screaming, then EMS (emergency medical services) and Police were here and took over ..." Interview on 6/7/18 with FC #3 revealed: -She felt that the facility wasn't ready to open. She indicated that for example, the daily schedule ran behind and staff were inconsistent in different areas. -She indicated that there were usually three staff working and two staff at night. Bed checks were conducted at night. -There were times the clients were in the group room without a staff member. She later indicated in the interview that staff were with her all the time. -The staff did not do anything any different with her regarding her supervision. -Staff were present at the door when clients had to go to the bathroom. The door had to be cracked and they had to count. Immediately following a meal staff would be in the bathroom facing the door. -She did not want to discuss the scratches on her arm but did indicate that she did not have a rash. -She refused to discuss the incident on 5/24/18. -She indicated that the therapist checked in with her a couple of times about her urges to self-harm. -She stated that she felt safe while in the facility.	V 111		

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V 111	Continued From page 16 Interviews on 6/6/18 and 6/11/18 with the mother of FC #3 revealed: -FC #3 was sexually assaulted by a group of boys at age 12. Since that time FC #3 had experienced PTSD and had episodes of self-harm and a number of serious efforts to attempt suicide. She stated that her daughter had been in facility after facility and on many medications. -FC #3 had used shirts, socks, blankets, and towels before to strangle herself. -When FC #3 was admitted there was no clear crisis plan in place. She met with the therapist one time while FC #3 was there but no crisis plan was done. -She had not been involved in the admission process but would have liked to have been. No one at the facility talked to her about FC #3's history of self-harm. -She did not discuss treatment goals with the therapist. She indicated they "didn't get very far". -During the one session she had met with the therapist they discussed the wound on FC #3's arm. She indicated that the facility thought it was dry skin that was causing itching. -She stated that she informed the therapist that she did not believe the scratching had been caused by dry skin. She indicated that she told the therapist that FC #3 scratches and they better keep an eye on it. FC #3 had never been diagnosed with eczema. -She informed them that FC #3 is most likely anxious and that is why she is scratching. -She stated that she told them that she hoped that FC #3 would not have the opportunity to be in a bathroom and self-harm. -She did not understand why her daughter was in a situation where she could do this. -"No one can handle her self-harm, eating	V 111		

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V 111	Continued From page 17 disorder and suicide attempts." -"[FC #3] is not predictable but scratching is a sign of high anxiety then her thought process can spin out of control." Former Client #4 (FC #4): Record review on 6/5/18 for Former Client #4 (FC #4) revealed: -Admitted on 5/16/18 with diagnoses of Bulimia Nervosa, Depressive Disorder, Anxiety Disorder, Social Anxiety Disorder, and Cannabis Use Disorder. -Discharged 5/24/18. -Age 17. -Biopsychosocial assessment dated 5/16/18 indicated the presenting problems as " ...client began restricting since 6th grade and it turned into binging and purging ...client will binge after using marijuana which increases her appetite, but then after the binge will purge to compensate ...she also restricts food ...substance abuse ...depression-client has been on antidepressants for two years ..." -Psychiatric evaluation dated 5/21/18 indicated " ...Hx (history) cutting behaviors, as recently as yesterday, but these have invariably been parasuicidal. She does have a history of SI but no suicide attempts. She has never formulated plan or had intent, but has experienced fleeting thoughts of wanting to no longer live ..." Review on 6/6/18 of the treatment plan for FC #4 revealed: -Treatment plan document dated 5/18/18 had no goals listed or staff interventions. -There were no strategies documented in the record to address FC #4's presenting problems. Review on 6/5/18 of the progress note dated	V 111		

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V 111	Continued From page 18 5/25/18 for FC #4 revealed: -"[FC #4] was present during self harm incident with another client despite staff attempts to keep her separated ...[FC #4] followed behind me as I ran up the stairs to help with the other client ...[FC #4] was emotionally effected. I again asked her to join the other clients and she still stayed with me and the other client. EMS (emergency management services) and Police arrived and asked us to step away ...I took [FC #4] downstairs and in attempts to calm her down ..." Interview on 6/7/18 with the parent of Former Client #4 (FC #4) revealed: -FC #4 indicated to her that on the night of the incident she and the other clients were with a staff member downstairs and FC #3 was with a staff member upstairs. The staff member upstairs (Staff #1) called for help. The staff member downstairs (House Manager) ran upstairs. FC #4 followed the House Manager upstairs. She stated that they had to kick in the door. FC #3 had a shirt around her neck and had lost consciousness. The House Manager was trying to get the shirt off from around her neck and told FC #4 to go get scissors. FC #4 found scissors in the day room and took them to the House Manager. FC #3 started breathing. -Her daughter (FC #4) was present for the event and was traumatized. -Her daughter was now self-harming. -She indicated it was a huge decision to send her to the facility for treatment and now she had taken five steps back. -Her daughter indicated that they were never left unattended by staff. Review on 6/5/18 of the internal incident report for the incident on 5/24/18 revealed: -" ...Client (FC#3) requested to use the bathroom	V 111		

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V 111	Continued From page 19 prior to snack. One staff stayed behind to accommodate. Said staff stood by the bathroom door with the door about 4-6 inch width crack per our policy. Staff reported hearing the client urinate and flush the toilet. Staff then verbalized the plan to go downstairs to join snack. Client then shut and locked the door ...Staff could not get the door open and called down for the House Manager to assist. House Manager came upstairs and other staff went downstairs to remove the other clients from the situation. Other client (FC#4) refused to follow instruction from staff to remain separate and followed after the House Manager upstairs. House Manager reports that she attempted to open the door, but could not initially due to client passed out blocking the swing space of the door. House Manager reports pushing the door open enough to see client with a tank top wrapped four times around her neck with 2-3 knots twisted acting as a strangulation. Client was passed out and House Manager could not confirm that the client was breathing and reports client's face turning purple ...House Manager attempted to block other client from coming into the bathroom unsuccessfully. House Manager reports that she asked the client (FC#4) to got tell staff that scissors were needed in an attempt to remove her from the scene. House Manager was successful in removing some of the knots before the other client returned with the scissors. House Manager reports that she was able to remove the tank top and get the client breathing again ...During the beginning of the event when staff went downstairs to remove clients to a safe space, staff called 911 and requested police and ambulance assistance ...police arrived followed shortly by EMS (emergency management services) and they took over the scene ..."	V 111		

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V 111	Continued From page 20 Interviews on 6/6/18, 6/11/18 and 6/12/18 with the House Manager revealed: -On the night of the incident she and Staff #1 were working. The group was upstairs and going downstairs. Staff #1 was with FC #3 at the bathroom. Staff #1 called to say they were coming down. When she reached the hallway to the kitchen Staff #1 called for help. She indicated that when Staff #1 turned to call down and say they were coming down that FC #3 closed and locked the door. At that point she ran upstairs and Staff #1 ran downstairs. -She was the staff member with the keys. She kept the keys with her because she administered the medications. Staff #1 did not have keys at the time of the incident. -FC #4 followed her upstairs and she advised her to return to the group. Staff #1 also called for FC #4 to return to the group but FC #4 did not comply. FC #4 did not return to the group and was present for the event. -She tried to enter the bathroom but indicated that FC #3 was pushing up against the door. She indicated that FC #3 then fainted and she was able to push in. She did not kick in the door. She indicated that when FC #3 fainted that she hit her head on the bathtub. -She stated that FC #3 was laying on her side and sounded like she was crying. The sounds stopped and then she noticed her face turning purple. -She indicated that when she first entered she could not see the shirt around the neck of FC #3. When she saw she immediately tried to untangle the shirt. -She indicated that she asked FC #4 to go downstairs and asked Staff #1 to bring up some scissors. FC #4 then returned with scissors. By the time she returned she had been able to release the shirt from the neck of FC #3.	V 111		

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V 111	Continued From page 21 -She stated that she stood up FC #3 and carried her into the hallway at which time she had begun to breathe and by that time EMS (emergency medical services) was coming up the steps. -They assumed that FC #3 had hidden the shirts in her pants. Three shirts were in the bathroom. One shirt had been used on her neck. -FC #4 was screaming, jumping around, and banging her head on the floor. Staff #1 allowed her to call her mom. -The protocol when a client was in the bathroom was that the door remain cracked and clients talk when in the bathroom. -She knew that FC #3 had a history of suicidal ideation, had PTSD (post-traumatic stress disorder), and an eating disorder. She indicated that she knew that FC #3 had attempted suicide in the past but did not know how recently. She further indicated that she had been told that FC #3 was in a hospital but did not know what for. She also stated that she "didn't know what [state psychiatric hospital] was". -FC #3 had never verbalized wanting to hurt herself. She indicated there had been no warning signs. On the night of the incident FC #3 seemed fine and had been compliant with the program. -Clients were never alone. Staff were to keep eyes on clients at all times. -She first indicated that there had been no increased supervision for FC #3, and then added they did keep her at arm's length. -There were no other strategies given to staff for the supervision and interaction with FC #3. On one occasion they had found that she had hidden food in a sweatshirt so they did implement a rule that no "hoodies" could be worn at the table. -There were no steps taken to restrict FC #3's access to articles of clothing or bath towels in the bathroom.	V 111		

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V 111	Continued From page 22 Interview on 6/7/18 with Staff #1 revealed: -She worked as an overnight staff. She and the House Manager worked the night of the incident. -She indicated that staff stayed with the clients where they went and kept clients in their eyesight "most of the time". She added that staff stayed at arm's length of the clients. -If a client was in the bathroom, the bathroom door was cracked and the client would talk. -On the night of the incident the group was upstairs and getting ready for snack. FC #3 indicated she had to go to the bathroom. She indicated that she stayed with FC #3 while the House Manager led the rest of the group downstairs for their snack. -She stated that the bathroom door was cracked and she was approximately 2 feet from the door. FC #3 was talking. She indicated that she encouraged FC #3 to hurry and then FC #3 slammed the door and locked it. She yelled for the House Manager to come up and as soon as the House Manager came up she went down and joined the group. She indicated that the House Manager was upstairs very quickly. -She did not have a key for the bathroom. -She stated that FC #4 followed the House Manager upstairs. -When she returned downstairs she called 911. -She indicated that FC #4 ran downstairs and got scissors. -She was on the phone with 911 until the police arrived. She indicated that the incident was very chaotic. -She had all the clients in the kitchen. FC #4 was crying and wanted to call her mother. -She knew that FC #3 had been in a state psychiatric hospital and knew that it was for mental health treatment. She stated that she knew that FC #3 had "issues going on and had done some self-harm".	V 111		

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V 111	Continued From page 23 -FC #3 did not show any signs of self-harm and never indicated an intent to self-harm. On the night of the incident she "seemed down". -FC #3 had a scratch on her arm but it looked like an old one. She never observed FC #3 do any scratching or picking at her skin. -She stated that the supervision for FC #3 was the same as the supervision for the other clients. -During the overnight bed checks were done every 15 minutes. For the first 2 nights they had conducted 5 minute checks on FC #3. Interview on 6/12/18 with a therapist in the PHP (partial hospitalization program) revealed: -FC #3 had been placed previously in the PHP. There had been an incident of self-harm in the bathroom following a therapy session. -FC #3 had brought a razor from home and had it hidden. She had gone to the bathroom following a session. They had a 3 minute rule for bathroom use. A staff member was outside the door and called her name. FC #3 did not answer and was holding the door. The staff member forced their way in and FC #3 had multiple cuts on her arm. -She had expressed concerns about FC #3 coming back into the residential program. She did not feel that the program was quite ready. She had expressed those concerns before the residential program opened to the former Program Director. -She had "concerns about keeping her safe". -She indicated that FC #3 had experienced extensive trauma and neglect. -She stated that FC #3 doesn't give cues. -She stated that she met with the therapist for FC #3 to share her concerns and to share historical information. -She indicated that the entire clinical team has turned over for the agency.	V 111		

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V 111	Continued From page 24 Interview on 6/12/18 with Staff #2 revealed: -She worked as an intern for the PHP program and as a Behavioral Technician for the residential program. -She had worked with FC #3 when she was formerly in the PHP program and in the residential program. -There been one incident of self-harm when FC #3 cut her arm but no suicidal ideation observed. -In the residential program staff always maintain clients "within 2 arms lengths". No sweatshirts were allowed to be worn at meals. -She indicated that FC #3 was "impulsive" and made "rash decisions". She further said that FC #3's demeanor presented as normal in spite of her impulsivity. -She had expressed her concerns to her Supervisor and the former Clinical Director. -She had participated in a treatment team meeting on 5/16/18 and at that meeting the team had discussed her history and the incident that had occurred while she was in the PHP program. -"There was not as much clinical feedback in the admission of [FC #3] that maybe there should have been." Interviews on 6/7/18 and 6/11/18 with the Therapist/QP (Qualified Professional) for FC #3 revealed: -She began working at the facility on 5/7/18 as a therapist. -The Clinical Director had resigned the first week after the facility had opened. -There was no Clinical Director, no supervision and no structure. The facility was working on hiring a new Clinical Director. -She was currently working a 2 week notice. She indicated that she "needed an organization that feels more safe and secure."	V 111		

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V 111	Continued From page 25 -The biopsychosocial was started for FC #3 on the day of admission. She did not believe the parent was present. The assessment was completed with FC #3. She was not aware that the parent should be part of the assessment process. She stated that parents should be involved. -The treatment plan for FC #3 was never completed. -"I really didn't know how to do it." -She had never been given a signature pad so she had not been able to have treatment plans signed by guardians. -There were no documented strategies in place to address the issue of self-harm or suicidal ideation. -She indicated that "maybe" staff were to keep FC #3 within arm's length. She stated that FC #3 was not left alone. She observed no warning signs with FC #3. She stated that FC #3 was not isolating from her peers. Interviews on 6/5/18 and 6/12/18 with the Supervisor for the Behavioral Technicians revealed: -A House Manager was on duty at all times. An extra staff worked during the day time and there was an overnight staff as well. During the daytime hours the therapists and administrative staff were also in the facility. -Clients were never left alone without staff. Clients cannot go upstairs without staff. Clients go upstairs as a group with a staff member present. -Staff accompanied clients to the bathroom, door is cracked and staff were at the door. Clients had to talk and there was a 3 minute timeframe to be in the bathroom. -The House Manager had keys to locked doors. Staff #1 did not have keys. The Site Coordinator	V 111		

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V 111	Continued From page 26	V 111		

had made several sets of keys but at that time only the House Manager carried the keys.
-She indicated that staff that were monitoring doors that could lock should have had keys.
-The staff working indicated the following occurred: All clients were going downstairs for snack and Staff #1 stayed behind for FC #3. Staff #1 was at the door and heard FC #3 urinate and flush. Staff #1 said "let's go down for snack" and then FC #3 shut door and locked it. Staff #1 called down for the House Manager. The House Manager came up and had to push in because FC #3 was against the door. Staff #1 then went downstairs. FC #4 followed the House Manager upstairs. FC #3 had used a shirt and wrapped it around her neck and knotted it. The House Manager asked FC #4 to get a pair of scissors from Staff #1. The House Manager was able to remove the shirt and stood her up. By that time the police had arrived.
-She indicated that FC #3 was very gifted at hiding her feelings and had reported to the therapist that she had experienced no urges to self-harm.
-She knew that FC #3 had self-harmed while in the PHP program. She knew about 1 prior suicide attempt but did not know when that was.
-There was a treatment team meeting on 5/16/18 at which time they discussed FC #3. She could not recall the extent to which they had discussed her history of self-harm. They did discuss keeping her in eyesight and conducting 5 minute bed checks at night. There were no notes taken at this meeting.
-Specific to FC #3 she had told the staff that FC #3 had a history of self-harm and that she had recently been in the state psychiatric hospital. She stated that she gave them de-escalation techniques to use and informed staff that they needed to "be within 5 paces" of her and have her

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V 111	Continued From page 27 in eyesight. She also had them conduct 5 minute bed checks. -She had talked to a therapist of the PHP program who expressed concerns about self-harming history about FC #3 coming into the residential program. The determination was made that FC #3 had 3 months in the state psychiatric hospital and was stabilized. She was unaware of the incident that had occurred in March while in the hospital. Interview on 6/12/18 with the Site Coordinator revealed: -He had always observed staff supervision of the clients. He had never observed clients left unsupervised. -He indicated a lot of transition for the facility due to the loss of the Program Director and Clinical Director. -The former Program Director wanted to get FC #3 into the program. -He stated that after the former Program Director left "things started falling apart". "She did a lot." Interview on 6/12/18 with the Licensed Practical Nurse (LPN) revealed: -She indicated that she knew nothing about FC #3's history or about the incident of self-harm that had occurred in their PHP program. -She recalled two treatment team meetings, one on 5/16/18 and the second on 5/23/18. At the meeting on 5/16/18 there was a quick introduction to the treatment team process and no discussions about FC #3. She said that during the next week information about the self-harm incident at the PHP program "leaked out" and then it was brought up at the meeting on 5/23/18. Interviews on 6/5/18, 6/7/18 and 6/12/18 with the Executive Director/RN (Registered Nurse)	V 111		

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V 111	Continued From page 28 revealed: -She reviewed all initial assessment information completed and submitted to her by the call center. -The Medical Director approved all admissions. -On the day of admission the client would sign paperwork and tour the facility. Then the client met with their therapist, the Nurse and the Dietician. The parent was involved in this process in an effort to obtain historical data. -The treatment plan was developed with the biopsychosocial assessment completed by the therapist. -A "Behavioral Modification Agreement" was completed for clients who voiced urges to self-harm while in care or for any client who acted out while in care. This plan would include target behaviors to eliminate and interventions for staff to use. They did not complete these agreements for clients who only had a history of self-harm. -They had obtained information from [two hospitals] for FC #3. -The information she looked at indicated that FC #3 had no suicidal ideation within the last year and no self-harm while in the state psychiatric hospital. -She indicated there were concerns expressed about taking FC #3 back into the PHP program but that no staff had expressed to her any concern about admitting her into the residential program. -She indicated that if a client had a prior suicide attempt within 6 months or was expressing suicidal ideation with a plan at admission then they would assess them to be "actively suicidal". A client's history of self-harm or suicidal ideation was reviewed and considered. -Goals were not indicated in the treatment plan for FC #3. A safety plan was not done. No strategies were documented to address the	V 111		

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V 111	Continued From page 29 presenting problems for FC #3 or FC #4. -She indicated that in hindsight they should have implemented a safety plan. Furthermore she stated that the person centered plan should have been completed and there should have been goals for FC #3. -She stated that staff kept FC #3 within eyesight and hearing distance. She indicated that FC #3 was provided one on one supervision and she did not go from room to room without a staff member. -FC #3 had a rash and was scratching the rash. This scratching was addressed with FC #3 and her mother and it was assessed to be a skin issue not an episode of self-harm. FC #3 denied that she self-harmed. -FC #3 was interacting well with staff and other clients. There were no warning signs or indicators. She had some self-loathing that was being addressed. -The protocol was for all staff to have keys to the bathrooms and for only the House Managers to have the keys for the medicine cabinet. Interview on 6/7/18 with the Program Director revealed: -She indicated that she started her job on 5/23/18. (Later clarified as 5/15/18). -Since the facility was licensed the Program Director and Clinical Director resigned. Additionally, two therapists had also submitted their letters of resignation. -Since she started she had been addressing personnel issues. She had been "swimming upstream". -She indicated she was "trying to stop the bleeding of people being anxious". -She had not met FC #3. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation	V 111		

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V 111	Continued From page 30 and must be corrected within 23 days.	V 111		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 31 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medications were administered as ordered, failed to ensure that all medications administered were ordered by a person authorized by law to prescribe drugs, failed to ensure MARs were current for 2 of 2 current clients (#1, #2) and 2 of 2 former clients (FC #3, #4), failed to ensure 3 of 3 audited staff (#1, #2, #3) were trained to administer medications, and 1 of 1 Registered Nurses (Executive Director/RN) failed to demonstrate competency in the administration of medications. The findings are: a) Client #1: Review on 6/5/18 of the record for Client #1 revealed: -Admitted on 5/22/18 with diagnoses of Bulimia Nervosa, Major Depressive Disorder, Anxiety Disorder, and Post-Traumatic Stress Disorder. -Age 16. Observation on 6/11/18 at 3:11PM of the medications for Client #1 revealed: -Vitamin D3 400 U, dispensed 5/29/18. -Buproprion (anti-depressant) 100mg, dispensed 5/25/18. -Melatonin (sleep) 3mg, dispensed 5/25/18. -Latuda (antipsychotic) 40mg, dispensed 5/25/18. Review on 6/11/18 of the physician orders for Client #1 revealed: -Vitamin D3 400 U, two daily, dated 5/25/18. -Buproprion 100mg, one twice daily, dated 5/25/18. -Melatonin 3mg, one at bedtime, dated 5/25/18. -Latuda 40mg, one daily, dated 5/25/18. -No physician order for Ibuprofen or Ondansetron (nausea).	V 118		

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V 118	Continued From page 32 Review on 6/11/18 of the 5/2018 and 6/2018 MARs for Client #1 revealed: -The May MAR indicated that the administration of Latuda did not begin until 5/29/18. -The May MAR indicated that the administration of Buproprion and Melatonin did not begin until 5/28/18. -The documentation on the May MAR is unclear as to when the Vitamin D was begun but it was not on the date ordered by the Nurse Practitioner. -The May and June MARs indicated that Ibuprofen 200mg was administered on 5/25/18 and 6/5/18 and Ondansetron was administered on 5/31/18, 6/1/18, twice on 6/2/18, 6/3/18 and twice on 6/4/18. -The MARs did not indicate time of administration and there were no staff names to coincide with their initials. b) Client #2: Review on 6/11/18 of the record for Client #2 revealed: -Admitted on 5/22/18 with diagnoses of Bulimia, Anxiety Disorder, Post-Traumatic Stress Disorder, Autism, and asthma. -Age 13. Observation on 6/11/18 at 3:11PM of the medications for Client #2 revealed: -Abilify (Antipsychotic) 2mg, dispensed 6/2/18. -Phenergan (nausea), 12.5mg, dispensed 5/23/18. -Therems Tablet vitamin, dispensed 5/23/18. -Hydroxyzine (anxiety) 50mg, dispensed 5/23/18. -Albuterol (asthma), dispensed 4/26/18. Review on 6/11/18 of the physician orders for Client #2 revealed: -Abilify, 4mg daily, dated 5/18/18. -Trazodone (anti-depressant) 50mg, one at	V 118		

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V 118	Continued From page 33 bedtime, dated 5/25/18. -Hydroxyzine 50mg, one at bedtime, dated 5/18/18. -The order for Phenergan stated only "PRN (as needed)". No instructions for administration were indicated. -The order for the Albuterol inhaler stated only "PRN (as needed)". No instructions for administration were indicated. -No physician's order for the Therems vitamin. -No physician's order for the Multi Minerals-Ferrous liquid (vitamin). -No physician's order for Tylenol. Review on 6/11/18 of the 5/2018 and 6/2018 MARs for Client #2 revealed: -The May MAR indicated that the Abilify was "out" from 5/27/18-5/29/18. -The May MAR listed "multi minerals-ferrous, 1 tablespoon daily" and indicated daily administration from 5/24/18-6/11/18 (with the exception of 6/6/18 when it was missed). -The May MAR indicated that Trazodone administration did not begin until 5/29/18. -Tylenol 650mg was administered on 5/30/18. -The administration of Hydroxyzine was not documented in May or on 6/1/18. It was documented daily beginning on 6/2/18. -The MARs did not indicate time of administration, instructions for some of the PRN (as needed) medications, and there were no staff names to coincide with their initials. c) FC #3: Record review on 6/5/18 for FC #3 revealed: -Admitted on 5/15/18 with diagnoses of Anorexia Nervosa, Bulimia Nervosa, Bi Polar Disorder, Post-Traumatic Stress Disorder (PTSD), Anxiety Disorder, Borderline Personality Disorder, and Disrupted Mood Dysregulation Disorder.	V 118		

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V 118	Continued From page 34 -Discharged 5/24/18. -Age 16. Review on 6/11/18 of the physician orders for FC #3 revealed: -No physician's order for Ondansetron (nausea) 4mg. Review on 6/11/18 of the 5/2018 MAR for FC #3 revealed: -Ondansetron 4mg was administered twice on 5/17/18. -The MARs did not indicate time of administration. d) FC #4: Record review on 6/5/18 for Former Client #4 (FC #4) revealed: -Admitted on 5/16/18 with diagnoses of Bulimia Nervosa, Depressive Disorder, Anxiety Disorder, Social Anxiety Disorder, and Cannabis Use Disorder. -Discharged 5/24/18. -Age 17. Review on 6/11/18 of the physician orders for FC #4 revealed: -No physician's order for Trinessa Lo (birth control), one table daily. -Zoloft (anti-depressant) 75mg daily, dated 5/21/18 and increase to 100mg daily on 5/22/18. -No physician's order for Prozac (anti-depressant). -No physician's order for Zoloft on the day of admission which was 5/16/18. -No physician's order for Ibuprofen (pain) 200mg. -No physician's order for Milk of Magnesium (antacid and laxative) 15ML. Review on 6/11/18 of the PA's (physician	V 118		

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V 118	Continued From page 35 assistant) notes dated 5/18/18 revealed: -" ...she was recently evaluated by [doctor] at [medical practice] and is on a Prozac taper and Zoloft titration ..." -" ...Prozac taper, dose was 40mg daily ...Zoloft 25mg daily with orders to titrate dose ..." Review on 6/11/18 of the 5/2018 MAR for FC #4 revealed: -Trinessa Lo tablet administered daily. -Prozac 10mg at bedtime was administered from 5/16/18-5/20/18. -Zoloft 25mg, 3 tablets at bedtime was administered beginning on 5/16/18 prior to the order on 5/21/18. -Ibuprofen 200mg was administered on 5/18/18 and 5/21/18. -Milk of Magnesium 15ML was administered on 5/21/18. -The MARs did not indicate time of administration and there were no staff names to coincide with their initials. Review on 6/7/18 of the personnel record for House Manager #1 revealed: -Hired 5/11/18. -Document titled "Medication Policy and Procedure Training Agreement" which indicated that the House Manager "received training on Medication policy and procedures for [licensee]". The document was dated 5/11/18 and signed by the House Manager and the Regional Behavioral Technician Supervisor. Review on 6/11/18 of additional medication training documentation for House Manager #2, and House Manager #3 revealed: -Document titled "Medication Policy and Procedure Training Agreement" which indicated that the House Manager "received training on	V 118		

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V 118	Continued From page 36 Medication policy and procedures for [licensee]". The document was dated 5/11/18 and signed by the House Manager and the Regional Behavioral Technician Supervisor. Interview on 6/7/18 with the parent of FC #4 revealed: -She had never signed a consent for PRN medications to be given. -She was very concerned that her daughter had been given a laxative while in an eating disorder program. She indicated that the LPN was not aware that this had occurred. -She also indicated that on one night her daughter had run out of a medication. She contacted the nurse who then was able to get the medication by midnight. She stated they woke her daughter to give her this medication but failed to give her water to take with it. Interview on 6/12/18 with the Regional Behavioral Technician Supervisor revealed: -Only House Managers administered the medications. -The date of hire for House Manager #2 was 5/14/18 and House Manager #3 was 5/31/18. -She talked to the House Manager about the policies for medications and had that documented. -She stated that the LPN trained the House Managers on medication administration. Interviews on 6/11/18 and 6/12/18 with the LPN revealed: -The "orders" in the electronic medical record have a "begin date" and "end date". There was confusion as to if the begin date was when a client entered the program or when the medication started. -She did not know that administration times	V 118		

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V 118	Continued From page 37 needed to be on the MAR. -She had been told that the Regional Behavioral Technician Supervisor was providing the medication training to staff. -She "trained" one of the House Managers but she could not remember which one and had no documentation to indicate when and with whom that was. -She had been given "bits and pieces" of training on the electronic medical record. She did not know where to find the electronic medication orders. -The facility maintained a list of PRN (as needed) over the counter medications that each parent signed consent for at the time of admission. Neither the Nurse Practitioner (NP) nor PA (physician's assistant) had signed for the administration of those medications. -The parents for FC #3 and FC #4 never signed a consent form for the administration of the PRN medications. -Clients entered the program with their medications from home or a prior placement. Clients were then assessed by both the LPN, and NP or PA within 48 hours. The House Manager would complete the initial MAR if she was not present. -She was responsible for completion of the MARs each month. -The NP either gave her a verbal order for a medication that she would then call in to the pharmacy or he sent the electronic order directly to the pharmacy. In either circumstance she did not know how the orders got signed by the NP. -She did not know that FC #4 had been given Milk of Magnesium until she was called by FC #4's mother. She reported that to the NP. When FC #4 was admitted she brought medications from home. She did not know if anyone had contacted the Primary Care Physician to get the	V 118		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

(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 118	Continued From page 38 initial orders for her medications. -On one occasion a medication was delivered at 11:30 PM for FC #4. She instructed staff to wake FC #4 and administer the medication. She could not remember which medication it was. -There had been issues with medication deliveries from the pharmacy. This problem was being addressed. -There was no consistent system in place for the oversight of medication administration. "It has been hit or miss." -She had not seen any facility policies or had any facility orientation. -She was not aware of the state rules for medication administration. -"The whole thing is a mess." Interview on 6/12/18 with the Executive Director/RN revealed: -She is a Registered Nurse (RN). -The LPN was supposed to review the MARs daily and address any errors. -The LPN was also responsible for training staff in the administration of medications. The Regional Behavioral Technician Supervisor was only to train on policies. -She did not train any staff. -She did not routinely monitor medication administration. -She knew there were issues with deliveries from the pharmacy and she had addressed this problem with the pharmacy. She had arranged delivery timeframes and alerts by email for refills. -All physician orders were entered into the electronic record and the NP would review and sign. -She was in the process of hiring a Pediatric Nurse Practitioner. -She did not understand why there were problems with medication administration.	V 118		

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V 118	Continued From page 39 This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care.	V 179		

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V 179	Continued From page 40 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to operate within the scope of their program which is to provide a structured living environment within a system of care approach for adolescents who have diagnoses of mental illness, emotional disturbance or other disabilities, affecting 2 of 2 current clients (#1, #2) and 2 of 2 former clients (FC #3, FC #4). The findings are: Cross reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V111) Based on record review and interviews the facility failed to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan affecting 1 of 2 current clients (#1) and 2 of 2 former clients (FC #3, FC #4). Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review, and interview the facility failed to ensure that 1 of 1 audited Qualified Professionals (QP/Therapist) demonstrated knowledge, skills and abilities required by the population served. Cross reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) Based on record review and interviews the facility failed to ensure staff were trained to meet the treatment needs of the clients and failed to ensure that a	V 179		

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V 179	Continued From page 41 staff member who was trained in first aid and CPR (cardiopulmonary resuscitation) was available at all times when clients were present in the facility effecting 4 of 4 audited staff (Staff #1, the House Manager, QP/therapist, and Behavioral Technician Supervisor). Cross reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVE TO RESTRICTIVE INTERVENTIONS (V536) Based on record review and interviews the facility failed to ensure that 3 of 4 audited staff (Staff #1, the House Manager, and the QP/Therapist) were trained in alternatives to restrictive interventions prior to the delivery of services. Cross reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366) Based on record reviews and interviews the facility failed to implement their written policy governing their response to level II incidents affecting 1 of 2 former clients (FC #3). Cross reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367) Based on record review and staff interview, the facility failed to report a Level II incident to the Local Mental Health Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident affecting 1 of 2 former clients (FC #3). Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) Based on record review and interviews the facility failed to ensure medications were administered as ordered, failed to ensure that all medications administered were ordered by a person	V 179		

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V 179	Continued From page 42 authorized by law to prescribe drugs, failed to ensure MARs were current for 2 of 2 current clients (#1, #2) and 2 of 2 former clients (FC #3, #4), failed to ensure 3 of 3 audited staff (#1, #2, #3) were trained to administer medications, and 1 of 1 Registered Nurses (Executive Director/RN) failed to demonstrate competency in the administration of medications. Review on 6/14/18 of the Plan of Protection signed and dated 6/14/18 by the Executive Director/RN revealed: Immediate Action Facility will take to ensure the safety of the consumers in our care: "-Assessment prior to admission - Assigned Therapist to review pre-admission assessment along with MD, Nurse and Program Director. The therapist and LPN will review all of the assessment information including all outside prior placement information. Therapist will then complete a safety plan and/or strategies at admission to address the presenting problems. This will be documented on the Individual Safety Protocol and uploaded into EMR. -Therapist will base initial PCP and treatment goals off of information obtained from Pre-admission Assessment and documentation received from previous providers and update weekly. The therapist and LPN -LPN will call client or parent of child one day prior to admission to review any history of Self Harm/SI behaviors. Executive Director reviewed with LPN calling parent/child to review admissions on 6/14/18 at 4:30pm. -Treatment Planning- -Therapist will base treatment goals and interventions around all current and past mental health diagnosis. Treatment plans are signed by the guardians. Therapist will review treatment	V 179		

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V 179	Continued From page 43 plan needs with all staff during treatment team each week. Any immediate treatment interventions required will be addressed by Therapist to Program Director. Program Director will review with Behavioral Tech Supervision, LPN and additional Therapists immediately. -Program Director will review the current cases you have for strategies/treatment goals/safety plans on 6/18/18. -Develop Protocol that any client who has had an active/lethal SI attempt in past 6 months would not be admitted to program. -Develop Mental Status and Medication Review Form for LPN to complete on call with client/parent prior to admission. Adding to nursing assessment in EMR -Competencies- -Program Director to meet with Therapists and review PCP and treatment plans to ensure Goals and Expectations are clearly documented and addressed. Once Clinical Director is onboarded, this will be under the expectation of this position. Program Director until Clinical Director is onboarded then this will fall to CD will review all of the strategies to ensure they are consistent with the presenting problems of the client. -Program Director will do ongoing oversight and monitoring to ensure compliance and the monitoring will occur on a weekly basis following each treatment team. -Personnel Requirements- -Working with corporate Human Resources to obtain specific training for CPR/First Aide/NCI Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18. -Working on having BH Tech Supervisor trained to provide CPR/First Aid and NCI training in house.	V 179		

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V 179	Continued From page 44 -Each staff member will be training in treatment needs of each client according to the needs specified in their treatment plan. Client specific training occurs/will occur at each Treatment Team which is an hour and a half each week. All oncoming clients are reviewed at the treatment team prior to admission. Program Director runs the treatment teams. For staff who are unable to attend the treatment team- immediate supervisor will review client specific information and they have access to review treatment team notes. Current clients are reviewed at each treatment team including their specific needs and treatment plans weekly. Program Director will monitor this to ensure it is completed. Documentation of the client specific training will be documented on the Treatment Team notes. -Working with corporate education to include Eating Disorder Specific Training, Trauma Informed Care, Specific Mental Health Diagnosis signs, symptoms and treatment Education to My Learning Pointe. -Incident Response- -Program Director or Administrator On Call will call the Emergency Contact once crisis has been addressed with client and staff. Program Director- will ensure that emergency contacts are called for an incident. if messages are left messages will be documented in EMR under memo to chart by the PD. -Incidence Reporting- -Incident Report will be completely submitted on IRIS System within 72 hours of Incident for Vaya clients. Incident Report will be submitted to Corporate Compliance within 72 hours for all clients. Program Director will be completing the IRIS reports. -Training on Alternatives to Restrictive	V 179		

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V 179	Continued From page 45 Interventions (NCI)- -Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18. -"Scheduled MEDPASS Class with Blue Ridge Pharmacy and House Managers. All new hires will attend MEDPASS Class at hire. We are awaiting date from Blue Ridge Pharmacy. It is a certification. A certificate of completion will be obtained and placed in employee chart. This training will occur by 6/23/18. LPN and RN developing MAR to include space for times of administration, client initials and staff signatures. LPN and MD will be reviewing meds and orders prior to admission to ensure orders are in the facility on the day of admission. Parental Consent forms updated to include Provider Signature, Date and Medication Revision completed. LPN to put orders into Doctors First Immediately upon Verbal Order from MD. MD to sign off on order. LPN to review MARS twice a week and will review MARS at each Treatment Team with staff and each client visit. RN to review MARS with LPN on Bi-weekly basis following Administrative Meeting. LPN to Review All Medication Orders weekly with MD. LPN to review and sign off on all staff Medication Administration Training. LPN providing training to all current staff and oncoming staff on Medication Administration training beginning on 6/13/18 and will be completed by 6/23/18. Each action is currently being implemented as of today."	V 179		

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V 179	Continued From page 46 Plans to make the above happen: -Assessment prior to admission- -Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review. Safety Protocol Form will be developed on 6/18/18. -Reviewed with LPN the role of calling client/parent to review all admissions. Site Coordinator will notify LPN of admission date and time. -Treatment Planning- -Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review. -Executive Director Meeting on 6/14/18 with Behavioral Tech Supervisor and LPN to develop Safety Protocol that will be based off of LPN findings from the Mental Status and Medication Review Form. -Submitted request to Carelogic to add the Mental Status and Medication Review Form to Nursing Assessment on 6/13/18. -Competencies- -Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review. -Personnel Requirements- -Trainings scheduled. -Behavioral Health Tech Supervisor researching options to train for CPI and NCI trainer.	V 179		

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V 179	Continued From page 47 -Incident Response- -Reviewed policy with Program Director and Administrators. -Incidence Reporting- -Program Director obtained training on IRIS on IRIS. 6/13/18. -Training on Alternatives to Restrictive Interventions (NCI)- -Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18. Immediate supervisors monitor and track trainings. Immediate supervisors schedule trainings. -Immediately following Incident the following was put into place-Lanyards with keys to all doors excluding Med Closet were issued to all staff. Med Closet keys are only issued to House Managers and Administrative Staff. Locks were removed from upstairs bathroom doors. Downstairs bathroom door locks only from outside with key. Plastic rings were placed on shower bars with break away shower bars." -"Message left with [Pharmacy RN] to schedule training for MEDPASS-2 Day Certification Class. Reviewing templates and requesting MARS within Pyramid Healthcare. Parental Consent Forms will be uploaded into CL and remain in MAR Notebook for staff review. PRN Consented Medications will be added to orders and MAR immediately upon admission. Executive Director and LPN scheduled meeting for 6/14/18 to set standing schedule and times for MAR reviews. Scheduled standing Bi-weekly meeting. MD contacted to set up weekly meeting.	V 179		

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V 179	Continued From page 48 LPN scheduling trainings." The facility admitted four clients with diagnoses of Bi Polar Disorder, PTSD, Borderline Personality Disorder, Anxiety, and Depressive Disorder in combination with Bulimia and Anorexia Nervosa. With full knowledge of their histories of self-harm and suicidal ideation, the facility failed to develop and implement strategies to address the treatment needs for Client #1, FC #3 and FC #4. FC #3, specifically, had an extensive history of self-harm, suicidal ideation, and multiple serious suicide attempts. These behaviors in addition to medical complications due to her eating disorder resulted in at least 18 hospitalizations. Most recently, FC #3 had a significant cutting incident in January 2018 while in the Licensee's PHP program. She was hospitalized in January where she remained until her admission to the program on 5/15/18. In March while hospitalized, FC #3 made a suicidal gesture and was found in her bed with a shirt tightened around her neck. There were no goals or interventions for her treatment developed by the therapist. No plan for her safety was discussed or implemented. No preventative measures were taken to restrict her access to items she might use to inflict self-harm. Bathroom doors were able to be locked from the inside and some staff who monitored those doors did not have keys. In failing to develop strategies to address her mental health, self-harm and suicidal ideation needs, staff did not have a clear understanding of the supervision needed to ensure her safety. When scratches were noticed on FC #3's arm, FC #3's mother advised the Therapist that FC #3 was experiencing increased anxiety and that the scratches were not due to a skin condition and this warning was ignore by the facility. Additionally, the facility failed to ensure that staff were trained to meet the complex	V 179		

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V 179	Continued From page 49 mental health needs of the clients, and failed to have staff present who had been trained in First Aid, CPR and alternatives to restrictive interventions. The Executive Director/RN was ultimately responsible for the proper administration of psychotropic medications that were critically important for the stability and safety of the clients. The RN failed to establish a system of checks and balances to ensure proper medication administration, failed to provide ongoing oversight to ensure the clients received their medications correctly, and failed to train staff to administer medications. Instead, she delegated those responsibilities to an LPN which were outside her scope of practice. The LPN did not have a clear understanding of medication policies and the electronic medical record. Physician orders were not in place for administration of medications to 4 clients. Physician orders were not followed for 3 clients. Due to the failure to accurately document medication administration it could not be determined if clients received their anti-depressant, anti-anxiety, and anti-psychotic medications as ordered by the physician. On 5/24/18 FC #3 almost died when she locked herself in a bathroom and strangled herself with a t-shirt. FC #4 witnessed the event and has been severely traumatized. This trauma has resulted in increased episodes of self-harm. These systemic failures resulted in serious harm and neglect for Client #1, Client #2, FC #3 and FC #4 and constitute a Type A1 rule violation and must be corrected with 23 days. An administrative penalty in the amount of $6000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 179		

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V 366	Continued From page 50	V 366		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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V 366	Continued From page 51 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 06/14/2018

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V 366	Continued From page 52 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement their written policy governing their response to level II incidents affecting 1 of 2 former clients (FC #3). The findings are: Review on 6/5/18 of the internal incident report for the incident on 5/24/18 revealed: -" ...Client (FC#3) requested to use the bathroom prior to snack. One staff stayed behind to accommodate. Said staff stood by the bathroom door with the door about 4-6 inch width crack per our policy. Staff reported hearing the client urinate and flush the toilet. Staff then verbalized the plan to go downstairs to join snack. Client	V 366		

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V 366	Continued From page 53 then shut and locked the door ...Staff could not get the door open and called down for the House Manager to assist. House Manager came upstairs and other staff went downstairs to remove the other clients from the situation. Other client (FC#4) refused to follow instruction from staff to remain separate and followed after the House Manager upstairs. House Manager reports that she attempted to open the door, but could not initially due to client passed out blocking the swing space of the door. House Manager reports pushing the door open enough to see client with a tank top wrapped four times around her neck with 2-3 knots twisted acting as a strangulation. Client was passed out and House Manager could not confirm that the client was breathing and reports client's face turning purple ...House Manager attempted to block other client from coming into the bathroom unsuccessfully. House Manager reports that she asked the client (FC#4) to got tell staff that scissors were needed in an attempt to remove her from the scene. House Manager was successful in removing some of the knots before the other client returned with the scissors. House Manager reports that she was able to remove the tank top and get the client breathing again ...During the beginning of the event when staff went downstairs to remove clients to a safe space, staff called 911 and requested police and ambulance assistance ...police arrived followed shortly by EMS and they took over the scene ..." Review on 6/12/18 of the "Written Emergency Procedures" policy revealed: -" ...In The Event of Self Harm or Suicide Attempt: ...The Program Director will contact the resident's emergency contact ..." Interviews on 6/6/18 and 6/11/18 with the mother	V 366		

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V 366	Continued From page 54 of FC #3 revealed: -On the night of 5/24/18 she received a call from a deputy with the local law enforcement agency. -She then called the facility and was told that FC #3 had tried to strangle herself and was sent to the local hospital. The facility did not contact her and left no messages on her voicemail. -No one from the facility had explained to her what had happened in the bathroom with FC #3. No one informed her that the facility had discharged FC #3 from the residential program. She had been told by the hospital staff that the facility had discharged FC #3. Interview on 6/7/18 with the Program Director revealed: -She had contact with the family of FC #4 following the incident on 5/24/18 but not the family of FC #3. She understood that the Nurse had contacted the mother of FC #3. Interviews on 6/6/18 and 6/12/18 with the Licensed Practical Nurse (LPN) revealed: -The House Manager had contacted her on 5/24/18 to ask a question about the electronic medical record. -She had contacted the Therapist and Nurse Practitioner to inform them of the incident that had occurred with FC #3. -She indicated that she did not call FC #3's mother and did not know who did. Interviews on 6/5/18, 6/7/18 and 6/12/18 with the Executive Director/RN (Registered Nurse) revealed: -The morning of 5/25/18 (day after incident) she had left a message for FC #3's mother. She also thought that the Nurse had contacted FC #3's mother. -The protocol for incident reporting was to call	V 366		

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V 366	Continued From page 55 911 first, then call immediate supervisor and therapist on call. The Program Director is also called and either they or the Nurse would contact the family. -She was in Pennsylvania at the time of the incident on 5/24/18. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
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 cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 56 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 include summary information as follows: (1) medication errors that do not meet the	V 367		

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V 367	Continued From page 57 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 record review and staff interview, the facility failed to report a Level II incident to the Local Mental Health Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident affecting 1 of 2 former clients (FC #3). The findings are: Review on 6/5/18 of the internal incident report for the incident on 5/24/18 revealed: -" ...Client (FC#3) requested to use the bathroom prior to snack. One staff stayed behind to accommodate. Said staff stood by the bathroom door with the door about 4-6 inch width crack per our policy. Staff reported hearing the client urinate and flush the toilet. Staff then verbalized the plan to go downstairs to join snack. Client then shut and locked the door ...Staff could not get the door open and called down for the House Manager to assist. House Manager came upstairs and other staff went downstairs to remove the other clients from the situation. Other	V 367		

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V 367	Continued From page 58 client (FC#4) refused to follow instruction from staff to remain separate and followed after the House Manager upstairs. House Manager reports that she attempted to open the door, but could not initially due to client passed out blocking the swing space of the door. House Manager reports pushing the door open enough to see client with a tank top wrapped four times around her neck with 2-3 knots twisted acting as a strangulation. Client was passed out and House Manager could not confirm that the client was breathing and reports client's face turning purple ...House Manager attempted to block other client from coming into the bathroom unsuccessfully. House Manager reports that she asked the client (FC#4) to got tell staff that scissors were needed in an attempt to remove her from the scene. House Manager was successful in removing some of the knots before the other client returned with the scissors. House Manager reports that she was able to remove the tank top and get the client breathing again ...During the beginning of the event when staff went downstairs to remove clients to a safe space, staff called 911 and requested police and ambulance assistance ...police arrived followed shortly by EMS and they took over the scene ..." Review on 6/6/18 of the NC IRIS (North Carolina Incident Reporting Improvement System) revealed no Level II incident reported had been completed. Interview on 6/7/18 with the Program Director revealed: -She indicated that she started her job on 5/23/18. (Later clarified as 5/15/18). -Since she started she had been addressing personnel issues. -She stated that she had completed the level II	V 367		

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V 367	Continued From page 59 report and had put the information in the IRIS system. -She did not realize that the information was not fully submitted. -Before the close of the survey she indicated that the report had been submitted. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	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. (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.	V 536		

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V 536	Continued From page 60 (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 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);	V 536		

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V 536	Continued From page 61 (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 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	V 536		

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V 536	Continued From page 62 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 train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 3 of 4 audited staff (Staff #1, the House Manager, and the Therapist/Qualified Professional) were trained in alternatives to restrictive interventions prior to the delivery of services. The findings are: Review on 6/7/18 of the personnel record for the House Manager revealed: -Hired 5/11/18.	V 536		

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V 536	Continued From page 63 -No training in alternative to restrictive interventions. Review on 6/6/18 and 6/7/18 of the personnel record for Staff #1 revealed: -Hired 5/15/18. -No training in alternative to restrictive interventions. Review on 6/11/18 of the personnel record for the Therapist/Qualified Professional (QP) revealed: -Hired 5/7/18. -No training in alternative to restrictive interventions. Interviews on 6/5/18 and 6/12/18 with the Supervisor for the Behavioral Technicians revealed: -She was the only staff member that had NCI (North Carolina Interventions) training. The NCI training was scheduled for 6/21/18. Interviews on 6/5/18, 6/7/18 and 6/12/18 with the Executive Director/RN (Registered Nurse) revealed: -The Behavioral Technician Supervisor was responsible for ensuring that training had been completed. -The Human Resource department should have sent a list about any training due to be completed. -The former Clinical Director had trained all clinical staff, however, the documentation of that training had disappeared. -She was unaware that NCI training had not been completed. This deficiency is crossed into 10A NCAC 27G .1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 536		

Plan of Correction for Tapestry Adolescent Residential Treatment Center

Type A1 Rule Violation: 10A NCAC 27G. 1301 Scope (V179) with crosses of 10A NCAC 27G .0205 Assessment and Treatment Habilitation of Service Plan (V111)
Type A1 Rule Violation: 27G .0203 Competencies of Qualified Professionals and Associated Professionals

Deficiencies in these areas due to failure to ensure that qualified professional demonstrated knowledge, skills, and abilities required by population served, failure to develop and implement strategies to address the client's presenting problem prior to establishment and implementation of treatment plan, and failure to provide structured living environment within a system of care approach for adolescents who have multiple diagnoses.

- (Tapestry Medical Screening Form, Prescreen Form, Biopsychosocial Assessment, Person Centered Treatment Plan, and Safety Plan Documents included in Plan of Correction Packet.)

Corrective Measures:

- As a result of the deficiency, the prescreen/ assessment protocol will be as follows- effective immediately:
    - Executive Director (previous) reviewed with LPN calling parent/child to review admissions on 6/14/18 at 4:30pm.
    - Program Director to meet with Therapists and review PCP and treatment plans to ensure Goals and Expectations are clearly documented and addressed. Program Director reviewed current cases for strategies/treatment goals/safety plans on 6/18/18.
    - Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review.
    - Safety Protocol Form developed on 6/18/18.
    - Prescreen is completed for each potential client by the Immediate Response Team Call Center.
    - IRT will collect the following information for each client:
        - Presenting problem
        - Needs and strengths
        - Provisional Diagnosis (to be established by reviewing clinician)
        - Pertinent social, family, and medical history
        - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
        - Completed Medical Form for each potential client including comprehensive lab results within the last 14 days and EKG.
        - Clinical record of previous and current treatment episodes and outpatient treatment providers.
    - Prescreen is reviewed within 24 hours by Program Nurse, Program Director or Executive Director, and MD.

- Program Director or Nurse contact family member/ guardian of potential client to assess for the following within 24 hours of completion of the prescreen:
    - Presenting problem associated with eating disorder symptoms and co-occurring conditions
    - Needs and strengths
    - Provisional Diagnosis
    - Pertinent social, family, and medical history
    - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
- Family Screening call will be documented in eCR in Progress Note (Memo to Chart)
- Program Director, Executive Director, Nurse, and MD review potential client details with treatment team including RDs and clinicians within 48 hours of the initial prescreen.
- If client is deemed psychiatrically and medically appropriate for admission and the clinical team assesses that the client will benefit from Tapestry services, admission details will be confirmed.

- On the day of admission, clinician facilitates biopsychosocial assessment to assess for the following:
    - Presenting problem associated with eating disorder symptoms and co-occurring conditions
    - Needs and strengths
    - Provisional Diagnosis
    - Pertinent social, family, and medical history
    - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
- Clinician completes treatment plan addressing the following areas:
    - Anticipated client outcome(s) from services provided and projected date of achievement.
    - Clinical strategies to address each presenting concern associated with eating disorder symptomology and co-occurring conditions.
    - Treatment team providers (staff) responsible for providing clinical services.
    - Schedule for Treatment Plan updates with client and guardian.
    - Outline of objective measures to assess for efficacy of treatment plan for each presenting issue.
    - Written consent from client and guardian for treatment plan for client.
- Clinical treatment team will review new admissions in weekly multidisciplinary treatment team meetings.
- Any safety issues noted in the prescreen will be communicated to the treatment team by the Program Director prior to admission.
    - A safety plan will be developed by the clinician prior to admission if there is any history of self harm or suicidal ideation noted in the prescreen or family prescreen.
    - The safety plan will be reviewed in a treatment team meeting facilitated by the Program Director and uploaded into the eCR for all clinical staff to access.

    - The safety plan will be reviewed with the client and guardian prior to admission and again at the time of admission.
    - Client safety will be assessed on a daily basis by clinician and recorded in daily progress note in the eCR.
    - Safety Plan Document will be available in eCR on 8/1/2018. Hard copies of Safety Plan will be used prior to this time and effective immediately as of 7/1/18.
- Clinical Program Requirements will be distributed to staff to ensure treatment team member awareness of expectations on 7/25/18. Clinical Program Protocol includes the following:
    - 2 individual sessions per week with therapist and client with documentation the day the service is provided.
    - 1 family session per week therapist and guardian/ family, and client with documentation the day the service is provided.
    - Comprehensive Treatment Plan within 24 hours of admission with weekly treatment plan updates
    - Medication management and MD consultation 1 x weekly for each client with documentation the day the service is provided.
    - PRN Nursing Services with 24 hour on call nursing staff
    - Daily psychotherapeutic process group with documentation the day the service is provided.
    - Daily psychoeducational group with topics pertinent to eating disorders and co-occurring conditions with documentation the day the service is provided.
    - Nutritional assessment within 24 hours of admission with RD and client with documentation the day the service is provided.
    - Weekly individual nutritional consult with RD with documentation the day the service is provided.
    - Daily nutritional groups and monitored meals with documentation the day the service is provided.
- Each current qualified professional will meet with Program Director and Executive Director to establish individualized supervision plan to occur on a routine basis to ensure appropriate, effective facilitation of treatment services.
    - Documentation of initial meeting and supervision plan will be stored in employee personnel file.
    - All employee supervision plans will be completed by 7/27/18 and stored in personnel file.
- Addition of training for Clinical Integrated Treatment for Trauma and Eating Disorders
    - All current staff will complete the training in My Learning Pointe by 7/29/18.
    - All new hires will complete the training as part of their initial training within the first 72 hours of their start date.
    - There will be an evaluation of competency for each participant that completes the training.
- Scheduled Acceptance and Commitment Therapy Training on 9/20/18 and 9/21/18 for treatment of eating disorders, trauma, substance use, and co-occurring conditions.

Compliance and Prevention:

- It is the responsibility of the Program Director to review each admission to assess for compliance to this policy.

- Admissions will not be approved without review of initial prescreen of Program Director, Executive Director, Nurse, and MD.
    - Exclusionary criteria includes individuals with active psychosis, active SI, suicide attempt within the last 6 months, and determined to be too medically acute by MD.
- All Biopsychosocial Assessments are reviewed and signed by the Program Director to ensure compliance with this policy.
- All incoming Biopsychosocial Assessments, treatment plans, and treatment plan updates are reviewed in weekly multidisciplinary treatment team meetings.
- All treatment providers have access to ECR to review LOC Assessment prior to providing services for the client.
- Professional development plans are created for each employee and are stored in personnel file by Executive Director and Program Director at time of hire and reviewed on a bi annual basis.
- All new hires will develop Individual Supervision Plans with Program Director at the time of their hire.

Monitoring:

- It is the responsibility of the Program Director to review each admission to assess for compliance to this policy
- It is the responsibility of the Program Director to conduct weekly chart audits on all charts to ensure compliance with this policy. Program Director will keep a record of weekly audits.
    - All current charts will be audited by Program Director as of 7/20/18.
- Individual Employee Supervision Plans will be reviewed by employee, Program Director, and Executive Director in conjunction with annual and semi-annual performance evaluations to monitor effectiveness and assess for continued needs.
- Program Director and Executive Director will meet weekly to discuss ongoing training needs for staff to ensure continued application of evidence based treatment interventions for clients with eating disorders, trauma, substance use, and co-occurring conditions.

Type A1 Rule Violation: NCAC 27G .0202 Personnel Requirements (V108)
Type A1 Rule Violation: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536)

Deficiencies were failure to ensure appropriate staff training.

Corrective Measures:

- As a result of change in leadership, all current employees are meeting with new Executive Director and Program Director to review job expectations and sign up to date job descriptions this will be complete on 7/29/18.
- As a result of the deficiencies cited above, all staff will be trained in the following by 7/29/18:
    - CPR and First Aid
    - NCI
    - Eating Disorder and Trauma Specific Treatment
    - Mental Health Treatment
    - Substance Use Disorder Treatment
    - Incident Response and Reporting training is scheduled for 7/13/18 and 7/17/18. All staff will attend.

- CPR/First Aide/NCI Trainings for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18.
- As a result of deficiencies cited above, management of the Personnel Files was moved to the Regional HR Director as of 7/10/18. Personnel Files will be maintained by Director of Human Resources and will include:
    - Up to date job description signed by staff member and supervisor
        - Minimum level of education
        - Competency
        - Work experience
        - Duties and responsibilities of position
    - Evidence of all training for employee, verification of licenses, certifications, and other qualifications.
    - Documentation of all continuing education
    - Documentation/ Evidence of:
        - New Employee Orientation
        - Client Rights and Confidentiality (10A NCAC 27C, 27D, 27E, 27F, and 10 NCAC 26B)
        - Specific Eating Disorder, Trauma Related Disorders, and Co-occurring Conditions Training for each Tapestry employee.
        - Infections Disease and Blood Borne Pathogen Training
        - First Aid and CPR certification
    - All staff members will be trained in Basic First Aid (including seizure management)
    - All staff members will receive in person CPR training by the Red Cross, American Heart Association, or their equivalency.

Compliance and Prevention

- It is the responsibility of the Regional HR Director to ensure that all new hires are scheduled for required trainings on their first day of employment.
- Regional HR Director will communicate training dates and times to employee and Program Director.
- Employees are not permitted to provide direct care to clients before completion of training requirements. Employees are permitted to observe other fully trained employees during the training process and/or within the first 90 days of employment.
- Employees are not be alone with clients until fully trained and must be with a fully trained staff member at all times prior to completion of all initial training. All staff will be trained in Eating Disorder and Trauma treatment at time of hire through My Learning Pointe in addition to ongoing training throughout the year through treatment team consultation with Executive Director, individual supervision with consultant, and monthly access to Certified Eating Disorder Specialist Training.
- Executive Director will organize four population specific trainings per year for program and provide opportunities for individual team members to seek out their own individualize treatment.

Monitoring

- Program Director will monitor new hire compliance with specific trainings.
- Executive Director and Regional HR Director will review personnel files for all new hires after 60 days of employment to ensure compliance.
- All new hire training is expected to be completed or scheduled at 60 days of employment.

- As a result of the deficiencies stated above, Executive Director and Vice President of Operations will meet and review personnel files with HR Director on 7/29/18 to ensure compliance with this correction.

Type A1 Rule Violation: 10 NCAC 27G .0604 Incident Reporting Requirements (V367)
Type A1 Rule Violation: 10A NCAC 27G .0603 Incident Response Requirements (V366)

Deficiencies include failure to provide written policy for level II incident response and failure to report to LME within 72 hours of learning about incident.

- (Incident Report Training document and Executive Incident Review Template included in Plan of Correction Packet)

Corrective Measures

- CQI Director will provide 1 hour training for all incident reporting requirements for current employees on July 13^{h} and 17th at 1pm. All employees will attend one of the trainings.
- Documentation of Incident Reporting Training will be maintained in employee personnel file and will be reviewed on 7/289/18 by Executive Director and Vice President of Operations.

Compliance and Prevention

- CQI Director will provide a 1 hour training for all newly hired employees on incident reporting requirements as part of the new hire orientation process. New hire orientation occurs within 90 days of employment. At no point will newly hired employees be alone with clients until they have completed their required New Employee Orientation Training.
- An Executive Incident Review Form will be completed after each Level III incident to ensure appropriate review and corrective action.
- An executive leadership team will review any Level III incidents within 48 hours of submission of the report.
- CQI Director and Executive Director will review incident reports bi-annually to monitor for trends.
- CQI Director will maintain a record of biannual incident review meetings.

Monitoring

- It is the responsibility of the Program Director to oversee the Incident Reporting Training. All employees that receive training will receive documentation of the curriculum covered within the training. Each training certificate will include summary of the curriculum covered, date and time of the training, signatures of the employee, CQI Director, Program Director, and Executive Director.
- A curriculum of training content will be maintained and updated as needed by CQI Director.
- An evaluation of competency will be conducted at the end of each training.
- Training for Incident Reporting will occur within 7 days of start date.

Type A1 Rule Violation: 10A NCAC 27G .0209 Medication Requirements (V118)

Deficiencies associated with failure to administer medications correctly as stated on orders, failure to obtain appropriate orders by legal provider, failure to maintain current MAR, failure to ensure appropriate training for staff, and failure to exhibit competency from RN/ Executive Director.

- RN/ Executive Director is no longer working for the organization and new leadership is established in the program effective 7/1/18.
- Appropriate, correct orders were obtained for each client and signed by MD on 7/13/18.Order will be stored in each client's paper chart, uploaded into the eCR document library, and placed in the MAR.
- All clients received written consent from guardians for current medication orders. Consents will be stored in paper chart and uploaded into Carelogic in the document library.
- Effective immediately as of 7/13/18, all medications, including standing orders, will only be dispensed with MD order.
    - Program Nurse, in consultation with program MD, developed medical records with medical notes, medical orders, and initial evaluations as of 7/13/18.
    - All copies of orders will be uploaded into Carelogic and stored in the Document Library of the eCR in addition to the paper copy located in the medical chart.
- All staff involved in medication administration will be trained in medication administration by state standards and program/ facility by 7/29/18.No untrained staff will provide med services prior to that time.
    - Nurse and staff member/ house manager attended Med Pass Class on 7/9 and 7/10.
- Tapestry nursing staff will ensure that medications provided for clients will only be dispensed with an order from a person authorized to prescribe medications by State of North Carolina.
- All current staff will be trained in medication administration by Blue Ridge Pharmacy (curriculum for training included in Plan of Correction packet). All new hires will be fully trained by an authorized medication administration trainer prior to providing client services associated with medications.
- All staff will be retrained in state approved medication administration on an annual basis.
- Development of a new MAR system to ensure the following:
    - Client's name
    - Name, strength, and quantity of the drug
    - Instructions for the administering the drug
    - Date and time of the administration of the drug
    - Name or initials of person administering the drug
- Development of system for management of medical records to ensure competent review of medical orders
    - Medication orders will be reviewed immediately following MD visits.

Compliance and Prevention:

- All new hires will be scheduled for state approved medication administration training at time of hire by Program Director.
- No staff member will be permitted to pass medications until they have received medical administration training that is up to state standards by an approved trainer.
- Program nurse will engage in routine observation of MAR process with each client/ trained staff member.
- MD will provide consultation progress notes for each medical visit and program nurse will review documentation to initiate any orders in a timely manner.
- The nurse will obtain written consent for all medication orders for minors.

Monitoring:

- It is the responsibility of the Program RN to routinely monitor the MAR for accuracy. Monitoring will occur on a daily basis.
- It is the responsibility of the Program Director to schedule all new hires for state approved medication administration training. Staff will not permitted provide any services related to medication prior to receiving state approved training.
- It is responsibility of the Program Nurse to ensure that all medications provided are only administered with an MD order.
- It is the responsibility of the nurse to ensure that all MD orders are initiated within 24 hours.
- It is the responsibility of the nurse to ensure that all guardians have provided written consent for any medication administered to a minor client. Orders will not be initiated prior to receiving guardian consent.

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

Facility Name: Tapestry Adolescent Residential Program

Rule Violation 10A NCAC 27G.1301 Scope with Crosses of Assessment & Treatment/Habilitation or Service Plan (VIII).

PLAN OF PROTECTION:

Immediate Action Facility will take ensure the safety of the consumers in our care:

- **Assessment prior to admission** – Executive Director, Program Director, Nurse, and MD/ PA will review pre-admission assessment. The therapist and LPN will review all of the assessment information including all outside prior placement information. Assigned therapist will then complete a safety plan and/or strategies at admission to address the presenting problems. This will be documented on the Individual Safety Protocol and uploaded into EMR.

- Therapist will base initial PCP and treatment goals off of information obtained from Pre-admission Assessment and documentation received from previous providers and update weekly. The therapist and LPN

  LPN will call client or parent of child one day prior to admission to review any history of Self Harm/SI behaviors. Executive Director (previous) reviewed with LPN calling parent/child to review admissions on 6/14/18 at 4:30pm .

- **Treatment Planning**-
  Therapist will base treatment goals and interventions around all current and past mental health diagnosis. Treatment plans are signed by the guardians. Therapist will review treatment plan needs with all staff during treatment team each week. Any immediate treatment interventions required will be addressed by Therapist to Program Director. Program Director will review with Behavioral Tech Supervision, LPN and additional Therapists immediately.

  Program Director will review the current cases you have for strategies/treatment goals/safety plans on 6/18/18.

  Develop Protocol that any client who has had an active/lethal SI attempt in past 6 months would not be admitted to program.

  Develop Mental Status and Medication Review Form for LPN to complete on call with client/parent prior to admission. Adding to nursing assessment in EMR>

- **Competencies-**
  Program Director to meet with Therapists and review PCP and treatment plans to ensure Goals and Expectations are clearly documented and addressed. Once Clinical Director is onboarded, this will be under the expectation of this position. Program Director until Clinical Director is onboarded then this will fall to CD will review all of the strategies to ensure they are consistent with the presenting problems of the client.
  Program Director will do ongoing oversight and monitoring to ensure compliance and the monitoring will occur on a weekly basis following each treatment team.

- **Personnel Requirements-**
  Working with corporate Human Resources to obtain specific training for CPR/First Aide/NCI Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18.

  Working on having BH Tech Supervisor trained to provide CPR/First Aid and NCI training in house.

  Each staff member will be training in treatment needs of each client according to the needs specified in their treatment plan. Client specific training occurs/will occur at each Treatment Team which is an hour and a half each week. All oncoming clients are reviewed at the treatment team prior to admission. Program Director and Executive Director (new) run the treatment teams. For staff who are unable to attend the treatment team- immediate supervisor will review client specific information and they have access to review treatment team notes. Current clients are reviewed at each treatment team including their specific needs and treatment plans weekly. Program Director will monitor this to ensure it is completed. Documentation of the client specific training will be documented on the Treatment Team notes.

  Working with corporate education to include Eating Disorder Specific Training, Trauma Informed Care, Specific Mental Health Diagnosis signs, symptoms and treatment Education to My Learning Pointe.

- **Incident Response-**
  Program Director or Administrator On Call will call the Emergency Contact once crisis has been addressed with client and staff. Program Director- will ensure that emergency contacts are called for an incident. if messages are left messages will be documented in EMR under memo to chart by the PD.

- **Incidence Reporting-**
  Incident Report will be completely submitted on IRIS System within 72 hours of Incident for Vaya clients. Incident Report will be submitted to Corporate Compliance within 72 hours for all clients. Program Director will be completing the IRIS reports.

- **Training on Alternatives to Restrictive Interventions (NCI)-**
  Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18.

Plans to make the above happen:

Assessment prior to admission-
Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review. Safety Protocol Form will be developed on 6/18/18.

Reviewed with LPN the role of calling client/parent to review all admissions. Site Coordinator will notify LPN of admission date and time.

Treatment Planning-
Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review.

Executive Director Meeting on 6/14/18 with Behavioral Tech Supervisor and LPN to develop Safety Protocol that will be based off of LPN findings from the Mental Status and Medication Review Form.

Submitted request to Carelogic to add the Mental Status and Medication Review Form to Nursing Assessment on 6/13/18.

Competencies-
Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review.

Personnel Requirements-
Trainings scheduled.

Behavioral Health Tech Supervisor researching options to train for CPI and NCI trainer.

Incident Response-
Reviewed policy with Program Director and Administrators.

Incidence Reporting-
Program Director obtained training on IRIS on IRIS. 6/13/18.

Training on Alternatives to Restrictive Interventions (NCI)-
Trainings are scheduled for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18. Immediate supervisors monitor and track trainings. Immediate supervisors schedule trainings.

Immediately following Incident the following was put into place-Lanyards with keys to all doors excluding Med Closet were issued to all staff. Med Closet keys are only issued to House Managers and

Administrative Staff. Locks were removed from upstairs bathroom doors. Downstairs bathroom door locks only from outside with key. Plastic rings were placed on shower bars with break away shower bars.

Rule Violation Cited: 10A NCAC 27.G .0209 Medication Requirements (VII8)

PLAN OF PROTECTION:
Immediate Action Facility will take ensure the safety of the consumers in our care

Scheduled MEDPASS Class with Blue Ridge Pharmacy and House Managers. All new hires will attend MEDPASS Class at hire. We are awaiting date from Blue Ridge Pharmacy. It is a certification. A certificate of completion will be obtained and placed in employee chart. This training will occur by 6/23/18.

LPN and RN developing MAR to include space for times of administration, client initials and staff signatures. EDIT Electronic MAR now included in all client ECRs.

LPN and MD/PA will be reviewing meds and orders prior to admission to ensure orders are in the facility on the day of admission.

Parental Consent forms updated to include Provider Signature, Date and Medication Revision completed.

LPN to put orders into Doctors First Immediately upon Verbal Order from MD. MD to sign off on order.

LPN to review MARS twice a week and will review MARS at each Treatment Team with staff and each client visit.

RN (at Corporate Office /ORI RN team) to review MARS with LPN on Bi-weekly basis following Administrative Meeting.

LPN to Review All Medication Orders weekly with MD.

LPN to review and sign off on all staff Medication Administration Training.

LPN providing training to all current staff and oncoming staff on Medication Administration training beginning on 6/13/18 and will be completed by 6/23/18.

Each action is currently being implemented as of today.

Plans to make the above happen

Message left with Tony Sherrill, RN to schedule training for MEDPASS-2 Day Certification Class. (Scheduled for 7/9 and 7/10).