STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 8/3/18. The complaints were substantiated. (Intake #s-NC139623, NC139701, NC139773.) Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Individuals with Mental Illness. 10A NCAC 27G .1100 Partial Hospitalization	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 107	Continued From page 1 (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to retain a signed job description for each staff position specifying minimum level of education, competency, work experience along with duties and responsibilities of the position for 3 of 5 current staff (Behavioral Health Technician (BHT) #1, BHT #3, Nurse #2) and 1 of 1 former staff (former Therapist #1). The findings are: Record review on 7/19/18 for BHT #1 revealed: -Date of Hire was 9/5/17. -No verification of education was available in personnel record. -No signed job description was available. Record review on 7/19/18 for BHT #3 revealed:	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 107	Continued From page 2 -Date of Hire was 5/14/18. -No signed job description was available in record. Record review on 7/19/18 for Nurse #2 revealed: -Date of Hire was 3/26/18. -No signed job description was available in record. Record review on 7/19/18 for former Therapist #1 revealed: -Date of Hire was 4/2/18. -No signed job description was available in record. Interview on 7/18/18 with BHT #1 revealed: -She had a bachelor's degree in Psychology. -She did not remember signing a job description. Interview on 7/19/18 with the Human Resources Director revealed: -She would expect every new employee to sign a job description with their supervisor on their first day of work. -There had been changes in leadership. -Sometimes those job descriptions did not come back. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 107		
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	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 108	Continued From page 3 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 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 provide training to meet the mh/dd/sa needs of each client as specified in their treatment plans for 5 of 5 current staff (Behavioral Health Technician (BHT) #1, BHT #2, BHT #3, BHT Supervisor, Nurse #2). The findings are:	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 108	Continued From page 4 Record review on 7/19/18 for BHT #1 revealed: -Date of Hire was 9/5/17. -Training in Substance Use/Addictive Disorders was signed 2/2/18. -No documentation of training on client specific needs for any of the current or former clients. -No documentation of training in Eating Disorders specifically Anorexia Nervosa or Bulimia. -No documentation of training in mental health diagnoses or mental health needs of clients. Record review on 7/19/18 for BHT #2 revealed: -Date of Hire was 12/10/17. -Training in Substance Use/Addictive Disorders was signed 6/25/18. -No documentation of training on client specific needs for any of the current or former clients. -No documentation of training in Eating Disorders specifically Anorexia Nervosa or Bulimia. -No documentation of training in mental health diagnoses or mental health needs of clients. Record review on 7/19/18 for BHT #3 revealed: -Date of Hire was 5/14/18. -No documentation of training on client specific needs for any of the current or former clients. -No documentation of training in Eating Disorders specifically Anorexia Nervosa or Bulimia. -No documentation of training in mental health diagnoses or mental health needs of clients. Record review on 7/19/18 for BHT Supervisor revealed: -Date of Hire was 4/30/18. -Training in Substance Use/Addictive Disorders was signed 6/7/18. Training in Trauma-informed care and Co-occurring Disorders was dated 5/11/18. -No documentation of training on client specific needs for any of the current or former clients.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 108	Continued From page 5 -No documentation of training in Eating Disorders specifically Anorexia Nervosa or Bulimia. Record review on 7/19/18 for Nurse #2 revealed: -Date of Hire was 3/26/18. -No documentation of training on client specific needs for any of the current or former clients. -No documentation of training in Eating Disorders specifically Anorexia Nervosa or Bulimia. -No documentation of training in mental health diagnoses or mental health needs of clients. Interview on 7/19/18 with BHT #1 revealed: -She described the training she had received as "very minimalistic". She indicated that she spent an hour with the dietician and reviewed language to use, nutrition information, exchanges, and common behaviors associated with eating disorders. She was provided "brief" training on Anorexia and Bulemia. She spent an additional hour with the Clinical Director and read through behavioral information, the suicide protocol and incident response/reporting information. She spent a couple of days shadowing another BHT. -She did not receive training in other mental health disorders. -She indicated that she learned by asking her co-workers questions. Interview on 7/19/18 with BHT #2 revealed: -She stated that when she started in November she did not receive training. She did have on line training a couple of months after she started. -She had shadowed another staff member a couple of times. She indicated that she "learned from other staff". She stated that "staff train themselves". Interview on 7/19/18 with BHT #3 revealed: -She had some on line training for eating	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 108	Continued From page 6	V 108		

disorders. The training "touched on" mental illness and substance abuse disorders.
-She indicated that most of her training about eating disorders had been "on the job".
-When a new client was admitted she asked the therapist about that person and would review the chart.
-Treatment team would typically review all current clients but did not review the new clients being admitted.

Interview on 7/19/18 with BHT Supervisor revealed:
-Training for the BHT staff included on line trainings, 3 days of shadowing, behaviors to look for with eating disorders and some supplemental information for eating disorders.
-She was responsible for training BHTs during the 3 days of shadowing.
-A lot of training provided was done on the job.

Interview on 7/19/18 with Nurse #2 revealed:
-She began working the end of March 2018 but was not trained on all of her duties until they came up.
-Two months into her job she was told to conduct the initial nursing assessments.
-The former Executive Director/Registered Nurse (ED/RN) did not provide any supervision to her.

Interview on 7/31/18 with the Executive Director revealed:
-We have reorganized and will have one Clinical Director and one RN along with three Site Coordinators and Lead Qualified Professional function as our leadership team. We will have more oversight and provide more enhanced training.

This deficiency is cross referenced into 10A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 108	Continued From page 7 NCAC 27G .5601 Scope (V289) for a Type A1 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 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.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 109	Continued From page 8	V 109		

This Rule is not met as evidenced by:
Based on record reviews and interviews 2 of 2 former Qualified Professionals (former Executive Director/Registered Nurse (ED/RN) and former Therapist #1) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:

Record review on 7/19/18 of Former ED/RN revealed:
Date of Hire 12/1/06 and date of termination 7/13/18.
RN verification date 7/20/99.

Record review on 7/19/18 for former Therapist #1 revealed:
Date of hire 4/2/18 and date of resignation 7/20/18.
Licensed Practical Counselor-Associate (LPC-A) verified 3/14/18.

Interview on 7/23/18 with former Therapist #1 revealed:
-Worked as an intern at this facility May 2016-May 2017 but came back to work as therapist, Licensed Practical Counselor Associate (LPC-A) 4/4/18.
-She was there about 1 ½ months before the Clinical Director quit. She was asked to take on some additional clinical responsibility but it was outside of her scope of practice.
-She was the only therapist on site from mid-May through the 1st of July 2018. Therapists from other programs helped fill in.
-The Clinical Director went on maternity leave in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 109	Continued From page 9	V 109		

November 2017 but returned only as a therapist. There was another Clinical director for a short time but she too left. There was still no Clinical Director.
-The house was run poorly by the former ED/RN.
-FC #6 was admitted from an inpatient unit in which she had starved herself down to 74 pounds.
-FC #6 was diagnosed with "scrupulosity OCD" (Obsessive Compulsive Disorder)-she would punish herself or self-harm based on wrongs she thought she had done to the world. If she talked too much in a conversation she would not allow time for others to speak and would harm herself. She began only speaking 26 words daily.
-FC #6 had a safety contract at admission for only AWOL (Absence without Leave) but agreed to an amendment the contract to include self-harm.
-FC #6 had sneaked medications out of her med box by distracting the BHT at a time when they were giving her ordered medications. "Overdose was [FC #1's] back up plan."
-"Some clients were sent to a higher level of care because the program was not working."

Interview on 7/30/18 with Former Clinical Director (CD)/therapist revealed:
-She had been Clinical Director prior to going on maternity leave November 2017. She returned the end of January 2018 serving only as therapist. She left employment at the end of April 2018.
-She had been the therapist for FC #6 during the client's first residential episode at the facility in 2017.
-FC #6 had been discharged from her first stay at the facility following ingestion of a capful of detergent and running off the property. She was discharged to a higher level of care.
-"[FC #6] had a masochistic mind set a year ago and was not appropriate for this level of care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 109	Continued From page 10	V 109		

-The Former ED/RN told the Former CD to write a safety contract for FC #6 to return despite not being the assigned therapist for FC #6 for the 2nd admission.
"[The Former ED/RN] was driving the facility way too hard and not training staff well enough for clients' needs."
-"[FC #6] had medication on her body that she could have used to overdose. Knowledgeable trained staff would have caught suicidal ideation/behaviors much earlier."

Interview on 7/19/18 and 7/24/18 with Nurse Practitioner (NP) revealed:
-"Since the [Licensee] had been bought out last year, key staff left causing a lot of confusion. There was a failure in leadership - planning, training, everything was chaotic. Such disorganization. They had 110% turnover in the last 6 months."
-With the former ED/RN, he was not involved in qualifying appropriate admissions. "One client brought her own meds and orders with her-she wasn't seen [by the NP] until the next week. Another client came in with opiates and benzos although I did not approve administration of her Oxycodone. I had no say with admissions."
-He was aware of 3 questionable admissions allowed by the former ED/RN. 1 client had a questionable EKG (electrocardiogram), 1 client had BMI (Body Mass Index) less than 15 and the client with the opiate addiction. The former ED/RN made all of the admission decisions without his input.

Interview on 7/31/18 with new Executive Director revealed:
-"Therapists were responsible for treatment planning with appropriate strategies to meet individual client needs. Oversight would be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 109	Continued From page 11 Executive Director until Clinical Director hired." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 110	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1 of 4 paraprofessionals (Behavioral Health Technician #1) demonstrated knowledge, skills and abilities required by the population served. The findings are: Interview on 7/31/18 with Behavioral Health Technician (BHT) #1 revealed: -She had worked the 9:00AM-9:00PM shift as a BHT for 1 year. -She indicated that Former Client (FC) #6 had a pre-disposition for self-harm. -She had worked with FC #6 when she was in the program before. -She was working the day that FC #6 drank fabric softener and eloped. FC #6 was discharged from the program at that time and had been hospitalized between admissions. FC #6 returned to the program in April. -On 5/25/18 during the meal preparation FC #6 was experiencing difficulty. She provided support to her and processed with her while the other clients waited for the meal to begin. FC #6 asked to use the restroom prior to the meal. She remained with the group in the kitchen. FC #6 returned to the table and ate the meal. Following the meal another client informed her that the bathroom smelled like chemicals. She went to the bathroom and also smelled chemicals. The closet that stored the cleaning supplies was unlocked. She asked FC #6 about what had occurred in the bathroom and FC #6 disclosed that she had found chemicals in the bathroom and had soaked a paper towel with "Goo Gone" and inserted that into her eye. FC #6 indicated	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 110	Continued From page 13 that it was painful at first but had not affected her vision. -The group had participated in a deep cleaning group late afternoon on 5/25/18. She had forgotten to lock up the cleaning supplies following that activity. She indicated that she normally tried to double check the cleaning supplies but that day she had failed to do so. Interview on 7/19/18 with Behavioral Health Technician (BHT) Supervisor revealed: -FC #6 found Goo Gone cleaner in the bathroom with which she attempted self-harm. Cleaners were usually locked in the closest in the bathroom. This was not a typical cleaning supply and she was not sure where it came from. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 14 annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. 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 behaviors effecting 1 of 1 former client (FC #6). The findings are: Record review on 7/31/18 for Former Client #6 revealed: -Admitted on 4/9/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Major Depressive Disorder, and Social Anxiety Disorder. -Discharged on 5/26/18. -Prior treatment episode in the program from July-September 2017. Review on 7/31/18 of the Pre-admission Assessment revealed: -Document dated and signed by the LPN (Licensed Practical Nurse) on 4/27/18, although client was admitted on 4/9/18. -" ...History of self harm ...burning ...history of suicidal ideation (SI) ...no self harm in last two weeks, suicidal ideations, no plan ..."	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 15 Review on 7/31/18 of the Biopsychosocial assessment completed by former Therapist #1 dated 4/11/18 revealed: -" ...presenting concern-anorexia and depression and OCD, restricting, exercising, self-harm, SI (suicidal ideation) ..." -"...Treatment History ...[hospital], 4 months, 12/12/17-4/9/18; ICU (intensive care unit), emergency psych ward, [hospital], a few weeks, Late Nov-12/12/17; [hospital] inpatient x2 June and July 2015 and June and July 2017, [residential facility] winter 2015-2016, [hospital] inpatient, 2 weeks May 2015 ..." -" ...physical abuse has all been self-imposed ..." -" ...History of Suicidal Ideation and current suicidal ideation ...passive suicidal ideation, has means but no plan or intent ...currently no plan ...overdose attempt in November 2017, hydrocodone, overdosed in the hospital ...2010-I tried to strangle myself ..." -" ...self-harming began at 12- 7th grade- cutter, 8th grade added in burning-burned through high school-pick wounds open-infect them, make them as painful as possible, In psych wards I will scratch or hit my head when I don't have access to sharps ..." -" ...client has strong thoughts and behaviors surrounding self-punishment in order to atone and live within her morals ..." Review on 7/31/18 of the Psych Evaluation completed by the NP (Nurse Practitioner) dated 4/10/18 revealed: -" ...The patient was discharged from here in September and readmitted to this program ...during the period of November-April, she was in psychiatric facilities ...relapsed in September ...ended up going to the hospital and overdosed there after sneaking in some opioid medications ..."	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 16	V 112		

-" ...burning scratching self as recently as 1-2 weeks ago ..."
-" ...first psychiatric admission at age 16 for cutting and ED (eating disorder) ..."

Review on 7/31/18 of an Incident Report dated 5/25/18 revealed:
-"[FC #6] report to RC (residential counselor), when asked directly that client self-harmed in the bathroom before dinner. Client reported pouring bleach and spraying "Goof Off" cleaner on her arms. Client reported when this did not produce the pain she desired spraying "Goof-Off" cleaner onto a paper towel until it was saturated and applying it to one of her open eyes. Client reported feeling desperate after reporting incident to RC. RC contacted Therapist on call. RC contacted police department. Client was taken to the hospital in an ambulance. RC left voicemail on client's mother's phone. Mother is approved by client to contact via release of information form. RC followed up with therapist on call and protocol was followed. (Therapist on call informed [Program Director] of situation)."

Review on 7/31/18 of the treatment plan completed by former Therapist #1 and dated 4/12/18 for FC #6 revealed:
-Goals included: develop and implement a daily ritual that interrupts the current pattern of compulsions; identify situations at risk for a lapse and strategies for managing these risk situations; identify high-risk situations and rehearse the management of future situations or circumstances in which lapses could occur; identify and replace biased, fearful self-talk and beliefs; verbalize and clarify feelings connected to key life conflicts; learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices; identify, challenge, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 17	V 112		

replace self-talk and beliefs that promote the anorexia or bulimia; identify and develop a list of high-risk situations for unhealthy eating or weight loss practices; and to implement relapse prevention strategies for managing possible future anxiety symptoms.
-No goals or strategies indicated in the treatment plan to address self-harm or suicidal ideation initially based on FC #6's history and the treatment plan was not updated as the self-harming behaviors increased.

Review on 7/31/18 of the Safety Contracts for FC #6 revealed:
-Document signed by FC #6 only. Dated 4/9/18. "Target Behaviors to Eliminate: elopement, self-harm. Interventions: checking in after meal times, advocating for alone time if over stimulated, practicing coming into the 'grey'-seeing how two things can exist at once, listening to music/distraction during, journaling, talking staff to de-escalate, keep hands busy-crochet-cleaning, talking to support system, reading, crossword puzzles, gratitude lists, be outside, walking. I agree to abstain from the above behaviors for the duration of my stay at Tapestry and understand that doing so is a condition of my continued stay. I understand that failure to do so can result in referral to a higher level of care/another program, or discharge from the program." Email dated 4/6/18 was reviewed and revealed that former Therapist #1 sent this "Behavior Contract" to the former Executive Director/Registered Nurse (ED/RN) and former Clinical Director.
-"Behavior Modification Agreement" dated 5/22/18 indicated "Target Behaviors to Eliminate: burning myself with things that I have heated in the microwave or on the stove. Interventions: I will not use the microwave, and if I cook with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 18	V 112		

stove or oven the RC (residential counselor) will need to watch my cooking. I agree to abstain from the above behaviors for the duration of my stay at Tapestry and understand that doing so is a condition of my continued stay. I understand that failure to do so can result in referral to a higher level of care/another program, or discharge from the program." This document was signed by FC #6 on 5/22/18. This document was created by a former Lead Therapist.
-"Behavior Modification Agreement" dated 5/23/18 indicated "Target Behaviors to Eliminate:
Self-harm in the form of burning, cutting, sandpapering, ingesting hazardous materials, hitting my head against something hard, scratching, infecting scabs. Interventions: I will instead use ice, gardening, walking, cleaning reading, writing, accepting help, read the news, singing. I agree to abstain from the above behaviors for the duration of my stay at Tapestry and understand that doing so is a condition of my continued stay. I understand that failure to do so can result in referral to a higher level of care/another program, or discharge from the program." This document was signed by FC #6. This document was created by Therapist #1.
- The initial safety contract dated 4/9/18 created by former Therapist #1 did not indicate any preventative measures put in place by the facility to address the self-harming behaviors of FC #6.
-Former Therapist #1 did not document any other safety contracts with FC #6 until 5/23/18. The contract on 5/23/18 also did not indicate any preventative measures put in place by the facility to address the self-harming behaviors of FC #6.

Review on 7/31/18 of the psychiatric follow up notes completed by the Nurse Practioner (NP) revealed:
-On 4/30/18 " ...she is likely minimizing her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 19	V 112		

symptoms ...she continues to indulge in macabre fantasies, such as imagining herself at her own funeral ..."
-On 5/7/18 " ...she has not directly harmed herself and burning or cutting this week although her urge to do so has been intense at times ...she also notes that she has thoughts to self-harm when she feels that she is not meeting the expectations of others ..."
-On 5/15/18 "The patient admitted last week to stockpiling some meds from her home supply to keep on hand in the event she might try to kill herself in the future. She says that she feels "safe" with the knowledge that a ready instrument for completing suicide is on hand ...she continues to have fleeting SI without intent ...she told staff on 5/12 that she has been thinking of burning herself on hot water kettle so it was taken away but she now admits that she had already burned herself at that point. She has 2 large (1-2") blisters on her R (right) wrist from this ..."
-On 5/22/18 "[FC #6] has several new, large burns on her R forearm adjacent to those seen last week. In the absence of a hot kettle (see 5/15 note) she has taken to overcooking hot water for tea in the microwave and burning herself on the lip of the mug ..."

Review on 7/31/18 of the Group Shift notes for FC #6 revealed:
-On 5/4/18 "Client was crying during dinner ...client reported having no reason to live. Client reported self-harm urges ...client appeared distressed. Client reported strong harm urges. Client reported urges to isolate. Client came up with a plan to keep her safe and engaged in activities and coping mechanisms ..."
-On 5/6/18 "Client appeared highly anxious during dinner prep ...RC (residential counselor) asked client about self harm urges and whether client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 20	V 112		

felt safe: client reported urges were "really high" and that she did not feel safe. Client continued to express hopelessness, stating that she feels a burden to others, that she is a bad person, and that she wishes she had died during previous suicide attempts. Client stated that she had been thinking about burning self all day ...client stated that she had collected glass and a lighter while on pass, but that she had not self harmed ...RC assessed client at high risk for self harm, SI, or elopement, and contacted CD (Clinical Director). Client met with CD and was able to contract for safety through evening ..."
-On 5/9/18 " ...Client reported her self harm urges to be an 8 out of 10 ...RC asked client around 9:00PM if she had engaged in any self harm behaviors. Client denied ..."
-On 5/13/18 " ...Client disclosed ...her self harm urges ranged from an 8-10 and her suicidal urges between a 9-10. RC encouraged client to use her coping and DBT (dialectical behavior therapy) skills ...client appeared withdrawn, quiet, anxious, and upset throughout the day."

Review on 7/31/18 of the Progress Notes completed by former Therapist #1 for FC #6 revealed:
-On 5/4/18 " ...Client presented as highly agitated from previous groups where her peers expressed concerns about her self-harm. Client reported negative self-talk and shame. Client reported feeling stuck and not able to move forward toward her goals ..."
-On 5/7/18 " ...Client reported that she self-harmed on Sunday. Client committed to safety today and handed over the instrument that she would have used to self-harm (sandpaper) ...Client contracted for safety ..."
-On 5/9/18 " ...Client contracted for safety from SIB (self-injurious behaviors) for tonight ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 21 -On 5/11/18 " ...Client reported that she had taken her meds out of her medication box again because she felt "safer" having it as an option. Client was willing to hand over her SI (suicidal ideation) means ...contracted for safety ...client is willing to be open with this author about her SI and SIB ..." -On 5/15/18 " ...Client reports experiencing urges to self-harm and no feeling comfortable with approaching other for support. Client reports that she will answer if she is asked a direct question, but feels compelled to not offer information ...Client is experiencing SI without means or intent. Client committed to safety ...clients affect was blunted, anxious, shameful and depressed ...Client appeared uncomfortable and shut down during the creation of the safety plan. Client was able to create a thoughtful plan and she appeared very uncomfortable doing so. Client appears to be experiencing strong urges to punish herself ..." -On 5/23/18 " ...Discussed client's self-harm behaviors and whether or not the client could keep herself safe at this level of care. Client discussed her urges to punish herself by burning ...Client contracted for safety knowing that self-harm would lead to the recommendation of a higher level of care ...Client continues to struggle with self-harm urges ...Client fears that she will not be able to keep safe due to feeling "mentally unsafe" ..." -On 5/25/18 " ...Client reported passive SI thoughts ...Client committed to safety and agreed to asking for help. Client appeared anxious and depressed ...Client was experiencing extreme negative talk and was unable to see her value. Client's pervasive negative self-talk from her OCD and ED (eating disorder) severely distorts her perception of herself ..." Interview on 7/31/18 with Behavior Health	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 22 Technician (BHT) #1 revealed: -She had worked the 9:00AM-9:00PM shift as a BHT for 1 year. -She indicated that FC #6 had a pre-disposition for self-harm. -She had worked with FC #6 when she was in the program before. -The treatment team was conflicted about the readmission of FC #6 to the program. The treatment team was split over what level of supervision she needed. Ultimately, the treatment team decided that FC #6 did not need one on one supervision and moved forward with her readmission. -Some members of the treatment team did not feel she was appropriate for the program and some wanted to give her a second chance. -There were other incidents of self-harm prior to the incident on 5/25/18. FC #6 would place her forearm under the hot water dispenser and scald herself. She heated mugs in the microwave as hot as possible and then use them to burn herself or use the stove top to burn herself. -FC #6 wore long sleeves to hide the burns and would not always disclose her self-harm. -FC #6 was in "active pursuit" to self-harm. -The supervision of FC #6 was the same as it was for the other clients. Her supervision was never increased due to her self-harm. The hot water dispenser had been removed and staff had been instructed to monitor her use of the microwave and stove. Interview on 7/19/18 with BHT #2 revealed: -She had been a BHT since November 2017 and worked the 9:00AM-9:00PM shift. -FC #6 was "constantly suicidal". She exhibited "a lot of self-harm". -FC #6 had a history of self-harm and had a previous treatment episode in the program.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 23 -"We did not have sufficient precautions for someone who had this much self-harm." -FC #6 had scars from previous self-harm and would try to reopen the scars. She also used sandpaper on her skin to self-harm that she found in the art room. Furthermore, she used hot water to burn herself. -She tried to stay next to FC #6 or make sure she had a "buddy". -She was not given any specific guidance to address the self-harm behaviors of FC #6. -She was told by another BHT that FC #6 had a history of self-harm. Interview on 8/1/18 with Nurse #2 revealed: -She was an LPN (Licensed Practical Nurse) and had been hired on 3/26/18. -She indicated that when FC #6 was admitted she had "scabs" on her left hand and left arm. FC #6 did not indicate that she had previously harmed herself. -She did observed fresh burns on FC #6 during her treatment episode. She stated that FC #6 "had huge burns on her wrist". The burns had blistered and wrapped around her wrist "like a bracelet". The wounds were not open or infected. -She stated that FC #6 had heated a cup in the microwave repeatedly and then held it to her wrist to self-inflict burns. Interview on 7/31/18 with new Executive Director revealed: -Therapists were responsible for treatment planning with appropriate strategies to meet individual client needs. Oversight would be the Executive Director until Clinical Director hired." -Safety plans should go through treatment teams and include ways to intervene; what worked for the client and what staff would be doing.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 112	Continued From page 24 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 112		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 25 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to keep the MAR current, failed to follow the written order of a physician, failed to verify documentation of physician orders and failed to demonstrate competency affecting 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former clients (FC #4, FC #5, FC #6, FC #7). The findings are: Review on 7/19/18 of Electronic Medical Administration Record (EMAR) report format revealed: -Client name, date of birth titled on page 1, then sequential date, time, name of medication and strength, count, staff name, prescriber, type (observed/administered), site (2 tablets/1 tablet/by mouth), missed (Y/N), STAT (Y/N) and comments (by mouth/1 tablet/2 tablets/blank). -The EMAR did not include the specific client's full list of medications ordered or instructions for administration including times or quantity to administer. -The EMAR reports for sampled clients revealed inconsistent reporting of observed or administered (type) and quantity (often noted under site or comments) although many entries did not include how many tablets were given. Counts were not consecutively reduced by the number given. No orders for self-administration were available. Finding #1 Review on 7/19/18 of incident report dated 6/20/18 revealed: Incident Start Time of 6/7/18 and the Incident Date of 6/20/18.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 26 Incident Description: "Client [#2] was admitted on 5/29/18 to Tapestry. Upon admission she gave information about her routine medications (she provided her medication bottles) Hydrocodone/Acetaminophen 10-325 as one of her medications-bottle read 1.5 tabs BID and 1 tab qHS. Client continued this dose until her PCP (Primary Care Physician) on 6/7/18 refilled the Rx decreasing the dose to 1 tab TID. This change was not noted and original dose was continued [for 23 days]. Client noticed her medication decreasing and discussed concern with [Nurse #2], it was noted at that time dose was given incorrectly. [PCP] was called immediately as well as Tapestry's Nurse Practitioner (NP). Interview on 7/19/18 with Nurse #2 revealed: -She was notified on 6/20/18 that Client #2's order for Hydrocodone had changed. Client #2's PCP prescribed the Hydrocodone for migraines and fibromyalgia. Her mom had brought in a newly filled bottle. The label on the bottle indicated the Hydrocodone should be given 3 times a day. The previous bottle label indicated 1 ½ tabs twice a day and 1 tab at bedtime. She contacted Client #2's PCP to clarify, called the facility's NP to inform and completed an incident report. -She wrote the MARs. Interview on 7/19/18 and 7/24/18 with Nurse Practitioner (NP) revealed: -The nurse should review all NP notes specifically for med changes. -He noted on 6/12/18 that PCP had changed dosage. -The nurse may have written the MAR from the bottle label. Finding #2	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 27 Record review on 7/19/18 for Client #1 revealed: Date of Admission was 6/28/18. Diagnoses included Bipolar I, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), Alcohol Use Disorder, Cannabis Use Disorder and Cocaine/Stimulant Use Disorder. Physician ordered medications included: --Excedrin Migraine 250-250-65mg 2 tabs once daily as needed (PRN) (pain). --Quetiapine Fumarate 50mg 1 tab at bedtime PRN (depression). --Lithium Carbonate 450mg- 2 tabs at bedtime (mood swings). --Lamictal 25mg 2 tabs once daily (mood). --Klonopin 1mg- 1 tab twice daily for up to the next 7 days (7/1/18) PRN (anxiety). --Ondransetron 4mg- 1 tab every 8 hrs PRN (nausea). --Benztropine 1mg once daily at bedtime PRN (tremors). --Tylenol Extra Strength 500mg 2 tabs every 6-8 hrs PRN (pain). Review on 7/19/18 of June and July 2018 MAR revealed: --Lithium Carbonate was blank on 6/30/18 as not administered. (1 dose) --Excedrin Migraine was administered twice on 7/4/18 and twice on 7/9/18. (2 doses) --Lamictal was given only 1 tab on 7/1/18. (1 dose) No tablet count/dosage was entered in EMAR for administration of the following: --Lithium Carbonate on 6/28/18, 7/4/18, 7/5/18. (3 doses) --Quetiapine Fumarate on 6/28/18, 7/4/18, 7/11/18. (3 doses) --Excedrin Migraine on 7/4/18, 7/5/18, 7/11/18. (3 doses) --Lamictal on 7/5/18. (1 dose)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 28 --Klonopin on 7/4/18(x2), 7/5/18(x2), 7/11/18(x2). (6 doses) --Bentropine on 7/4/18, 7/5/18, 7/11/18, 7/12/18. (3 doses) --Tylenol on 7/5/18. (1 dose) Record review on 7/19/18 for Client #2 revealed: Date of Admission was 5/29/18. Diagnoses included Bulimia, Bipolar II, Generalized Anxiety Disorder, PTSD, OCD, Panic Disorder and Cocaine Use Disorder. Review of May-July 2018 MARs revealed: Medications administered without an order from 5/29/18-6/20/18 (23 days) included: --Biotin 1 tab daily (Vitamin B-health). --Seroquel 200mg 1 tab at bedtime (mood stabilizer). --Promethazine 25mg three times daily before meals (nausea). --Alprazolam 0.5mg 1 tab four times daily PRN (anxiety). --Magnesium Oxide 400mg 1 cap every AM (antacid). --Estradiol 0.5mg once daily (hormone replacement). --Hydrocodone-Acetaminophen 10-325mg 1.5 tabs twice daily and 1 tab in PM (pain). --Prenatal Vitamins once daily (folic acid/iron-health). --Tizanidine 4mg ½ tab twice daily (muscle spasms). --Acetaminophen 325mg 2 tabs twice daily PRN (pain). --Gabapentin 400mg 2 tabs four times daily (pain). --Colace 100mg twice daily (constipation). --Reglan 5mg three times daily before meals (nausea). Additional medications administered but included in 5/29/18 psychiatric evaluation as a signed	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 29 order: --Olanzapine 10mg 1 tab at bedtime (depression). --Venlafaxine 150mg 1 tab every AM (depression). No MARs were available for 6/9/18-6/20/18 (11 days) to document administration of any medication. Psychiatric Evaluation dated 5/29/18 electronically signed by Nurse Practitioner (NP) referred to attached medication list although no list could be provided. The following medications were administered twice (initialed on paper MAR as well as entered into EMAR) on 6/1/18 PM doses: --Tizanidine --Olanzapine --Seroquel --Promethazine Paper MARs 5/29/18-6/8/18 revealed: -No staff names to coincide with the initials of staff who administered medications. -Unable to determine dates medications were given due to poorly scanned copy. No original was available. Review on 7/19/18 of Primary Care Physician (PCP) orders for Hydrocodone-Acetaminophen 10-325mg revealed: -Orders dated 4/21/18 and 5/16/18 indicated take "1 po tid to qid prn for pain." -No order for June 2018 was available. -Order dated 7/2/18 indicated "1 po tid prn for pain." The NP noted in 6/12/18 psych follow up note that "Rx sent by PCP of hydrocodone had been reduced to TID from QID." Hydrocodone had been administered 1.5 tabs twice daily and 1 tab in PM from 5/29/18 until 6/20/18 not according to PCP orders. June MAR was not updated to reflect NP notes on 6/12/18 but continued to administer	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 30 Hydrocodone at the higher dose. Record review on 7/19/18 for FC #4 revealed: Date of Admission was 2/12/18 and discharged 5/15/18. Diagnoses included Bulimia, Generalized Anxiety Disorder, PTSD, Depressive Disorder and Attention Deficit Hyperactivity Disorder (ADHD). Physician ordered medications included: --Latuda 40mg once daily after dinner (depression). --Prozac 20mg once in the morning (depression). --Zofran 8mg 3 times daily PRN (nausea). --Vyvanse 40mg once in the morning (ADHD). --Multivitamin once daily (health). --Ibuprofen 200mg 2 tabs every 4 hrs PRN (pain). Review of April and May 2018 MARs revealed: --Latuda was blank as not administered on 4/20/18, 4/21/18, 4/22/18, 4/24/18, 4/26/18, 4/27/18, 4/28/18, 4/30/18, 5/1/18, 5/3/18, 5/4/18, 5/5/18, 5/7/18-5/15/18. (21 days) --Prozac was blank as not administered on 4/30/18, 5/9/18, 5/12/18-5/15/18. (6 days) --Vyvanse was blank as not administered on 5/3/18, 5/5/18-5/7/18, 5/12/18-5/15/18. (8 days) --Multivitamin was not administered after 2/20/18 but remained listed on the MARs. There was no discontinue order. (45 days-April/May) --Wellbutrin 150mg once daily was administered without an order on the following days: 4/1/18-4/29/18, 5/1/18, 5/5/18-5/8/18. (34 days) Record review on 7/19/18 for FC #5 revealed: Date of Admission was 4/9/18 and discharged 5/30/18. Diagnoses included Bulimia, Generalized Anxiety Disorder, PTSD, OCD, Dysthymia and Alcohol Use Disorder Physician ordered medications included: --Fluoxetine 60mg once daily (depression).	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 31 --Multivitamin once daily (supplement health). --Vitamin B1 100mg once daily (supplement health). --Levetiracetam 500mg 1 tab twice a day (antiepileptic). --Vitamin D3 5000iu once daily (supplement health). --Vitamin B12 1000mcg once daily (supplement health). --Tri-Sprintec 28 once daily (birth control). --Doxepin 25mg once in PM (anxiety). --Hydroxyzine HCL 50mg every 6 hours PRN (anxiety). --Antabuse 250mg once daily (alcoholism). --Folic Acid 1mg once daily (anemia). Additional medications administered but for which there was no order: --Ferrous Sulfate once daily (iron supplement). --Potassium 99mg once daily (electrolyte). --Review on 7/19/18 of April/May 2018 MARs revealed: --Fluoxetine was blank as not administered on 4/30/18, 5/29/18, 5/30/18. (3 days) --Multivitamin was blank as not administered on 4/30/18, 5/29/18, 5/30/18. (3 days) --Vitamin B1 was blank as not administered on 4/30/18, 5/28/18-5/30/18. (4 days) --Levetiracetam was blank as not administered on 4/30/18 am/pm, 5/25/18 pm, 5/28/18 pm, 5/29/18 am/pm, 5/30/18 am/pm. (8 doses) --Vitamin D3 was blank as not administered on 4/30/18, 5/29/18, 5/30/18. (3 days) --Vitamin B12 was blank as not administered on 4/30/18, 5/28/18-5/30/18. (4 days) --Tri-Sprintec was blank as not administered on 4/30/18, 5/24/18, 5/25/18, 5/28/18-5/30/18. (6 days) --Doxepin was blank as not administered on 4/30/18, 5/15/18, 5/17/18, 5/23/18, 5/25/18-5/30/18. (9 days)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 32 --Antabuse was not listed on April MAR 4/9/18-4/30/18 and blank on 5/29/18, 5/30/18. (23 days) --Folic Acid was not listed on April or May MARs 4/9/18-5/30/18. (51 days) There was no discontinue order. --Ferrous Sulfate was administered without order 4/9/18-4/29/18, 5/1/18-5/27/18. (47 days) --Potassium was administered without order 4/9/18-4/29/18, 5/1/18-5/28/18. (48 days) Record review on 7/19/18 for FC #6 revealed: Date of Admission was 4/9/18 and discharged 5/26/18. Diagnoses included Anorexia Nervosa, Social Anxiety Disorder, OCD and Major Depressive Disorder. Medications administered without an order from 4/10/18-5/26/18 (46 days) included: --Colace 100mg once daily (constipation). --Miralax 1 scoop mixed with water daily (constipation). --Oxybutynin CL ER 10mg once in AM (incontinence). --Latuda 120mg daily after dinner (depression). --Effexor XR 225mg once in AM on April MAR as administered 4/10/18-4/29/18. (19 days) --Effexor XR 300mg once in AM on May MAR as administered 5/1/18-5/17/18, 5/19/18-5/25/18. (24 days) Record review on 7/19/18 for FC #7 revealed: Date of Admission was 5/8/18 and discharged 7/6/18 Diagnoses included Anorexia Nervosa, Generalized Anxiety Disorder, PTSD, OCD, ADHD and Depressive Disorder. Medications administered without an order from 5/8/18-7/6/18 (59 days) according to May-July 2018 MAR included:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 33 --Escitalopram Oxalate 15mg once daily (depression) given 5/11/18-5/17/18, 5/19/18-5/28/18. --Escitalopram Oxalate 20mg daily (depression) start 5/29/18. --Clonazepam 0.5mg ½-1 tab twice daily PRN (anxiety) given 5/11/18, 5/12/18, 5/15/18, 5/16/18, 5/17/18 (x2), 5/18/18 (x2), 5/19/18, 5/20/18 5/21/18 (x2), 5/22/18 (x2), 5/23/18 (x2), 5/24/18, 5/25/18 (x2), 5/26/18. (20 doses) --Zofran 4mg 1 tab three times daily PRN (nausea) given 5/30/18, 5/31/18 (x2). (3 doses) --Docusate 100mg 1 twice daily PRN (constipation) given 5/16/18, 5/19/18, 5/20/18, 5/21/18, 5/23/18 (x2), 5/24/18, 5/25/18, 5/26/18, 5/27/18, 5/28/18, 5/29/18 (x2), 5/30/18 (x2). (15 doses) --Biotin 5000mcg was given on 5/12/18, 5/14/18, 5/15/18, 5/17/18, 5/19/18, 5/21/18, 5/22/18, 5/23/18, 5/26/18, 5/28/18, 5/29/18, 5/30/18, 5/31/18. (13 days) --Ibuprofen 200mg 5/28/18 (4 tabs), 5/29/18 (4 tabs), 5/29/18 (unknown), 5/30/18 (4 tabs), 5/30/18 (3 tabs). (5 doses) --Zinc 50mg given on 5/28/18 (x2), 5/30/18. (3 doses) --Vitamin C 1000mg given on 5/28/18 (x2), 5/29/18 (x2), 5/30/18. (5 doses) --Nyquil 30ml given on 5/28/18, 5/29/18, 5/31/18. (3 doses) --Amoxicillin 875mg on 5/31/18. (1 dose) No MAR was available from 6/1/18-6/20/18 either written or electronic. (20 days) Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Interview on 7/19/18 with Client #1 revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 34 -BHTs gave meds-had never missed any. Always refilled. Interview on 7/18/18 with FC #7 revealed: -Ran out of Lexapro a couple of days because the pharmacy did not process an automatic refill. -Vitals every morning by HM. Used to take their own vitals with digital machine. -Saw Nurse Practitioner once a week on Tuesdays. Interview on 7/31/18 with Behavior Health Technician (BHT) #1 revealed: -There had been times that the medications ran out for clients. She indicated that the refill orders were not written in a timely manner and subsequently not called in timely. -She stated that when a medication had 7 days left she would advise the nurse who in turn called the NP (Nurse Practitioner) who then called in the refill. -She stated that Former Client #6 (FC #6) went four days without her medication for her mental health disorder. She indicated that other clients had also gone periods of time without their medications refilled but could not specify who, timeframe, or medication. Interview on 7/19/18 with BHT #2 revealed: -She indicated that medications had run out "a lot of times". -She indicated there were incidents when clients went "several days to a week" without medications. -She stated that at admission it typically took a few days to get the medications started for the clients. -She stated there were incidences when medication refills were not timely. -FC #6 had run out of her anti-depressant but it	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 35 did come late "after much advocacy". Interview on 7/19/18 with BHT #3 revealed: -When medications needed a refill she would text or email the nurse. The nurse would put in the order to the NP who would then send to the pharmacy. -She indicated one client who missed a medication for one night during July because the refill had not been delivered by the pharmacy. The medication arrived the next day. -The LPN had trained her in medications. Interview on 7/18/18 and 8/1/18 with Nurse #2 revealed: -She was an LPN (Licensed Practical Nurse) and had been hired on 3/26/18. -When she was hired the former Executive Director/Registered Nurse (ED/RN) told her that the NP (Nurse Practitioner) wrote the orders for everything and that house medications could be given to the clients. -Two months into her job she was told to conduct the initial nursing assessments. -The former ED/RN had no role in the administration of medications. -The former ED/RN did not provide any supervision to her. -She had voiced concerns to the former ED/RN about the electronic medical record. -She handled all medications at admission and wrote the initial MAR (medication administration record). -There was no system of oversight. The MARs were not reviewed for errors. -There had been no system to ensure there were physician orders for each medication. She indicated that she thought the NP or PA (Physician's Assistant) were checking that. -She did not recall any client going without	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 36 medications for a two week period and did not recall FC #6 being without her anti-depressant for 4 days. -The Former ED/RN told her to begin entering all medication management in EMR (Electronic Medical Record) on 6/1/18. She was not aware the electronic program was not completely set up to handle orders or current medication administration. The facility switched back to using paper MARs on 7/14/18. -The NP believed he had submitted orders electronically although she was unable to pull signed orders from the EMR. -She thought NP's notes were automatically converted to Doctor's orders in their electronic system but when requested she could not pull them from the EMR. -The procedure for a client to request an over the counter (OTC) as needed (PRN) was for staff to call the nurse. The nurse would contact the NP for a verbal order. -They did not have standing orders for PRNs. -She was on-call 24/7 and could receive 35-45 calls per week. She would give medical advice but did not keep a log of these calls. -Only realized a couple weeks ago that the NP signature would not print so it appeared there were no orders. -Their contracted pharmacy provided med training twice monthly and would be training all their staff. Interview on 7/18/18 and 7/31/18 with Corporate Nurse (CN) revealed: -She worked for the Licensee and came to this facility on 7/13/18 to help with nursing, training issues, medication management and teach monitoring and accountability. -The MAR process had been completely changed to only use paper MARs again.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 37 -The nurse should be responsible for reviewing MARs weekly. -Had worked on medication error prevention. Staff were to check the MAR when they first clock into work to see what time meds were to be given. -"First we need to get policy clear to techs so we will be administering meds. I don't think we were ever allowing self-administration." -"Entering meds in the EMAR doesn't make sense because it is not set up like a typical MAR. It was started when it should not have been started. It was missing important pieces of information that staff didn't know was missing. It is a non-functional program." -The facility no longer had stock PRNs and their medication room had been better organized. -Only realized a couple weeks ago that the NP signature would not print so it appeared there were no orders. -Not able to pull up some MARs from EMAR-just lost records. -"We cannot determine if correct medication orders were followed." -Had changed protocols-"Moved back to medical records on paper to be safe and so everyone had access to document. -Started with making sure clients were getting the right medications and staff were documenting correctly; "intentional care." Interview on 7/19/18 and 7/24/18 with NP revealed: -Submitting his medication orders in the EMR began late last year. -Was not aware until this audit that orders in EMR could not be differentiated as to what he had signed or not. He was later told this EMR was never intended to be used as a medical record. -"Since the [Licensee] had been bought out last	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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	V 118		

year, key staff left causing a lot of confusion. There was a failure in leadership - planning, training, everything was chaotic. Such disorganization. They had 110% turnover in the last 6 months."
-He gave Nurse #2 verbal orders but then couldn't pull up his order in the system.
-"The EMR would allow 2 clients to be open at the same time which could have been disastrous."
-He would enter an order for a medication 1 week and could not see it in the system the following week.
-He instructed Nurse #2 not to give Client #2 Tylenol along with the Hydrocodone she came in with. He was not sure this was made clear to all staff as there was no instruction provided in the EMR where medication administration was documented.
-There were problems with refills that he would send to the pharmacy through the electronic system.
-The pharmacy relied on the facility to call in refills even though it had been sent electronically.
-He did not write standing orders- PRNs had to be written individually.
-He did not write any self-administer orders-"wanted to minimize the risk."
-Nurse #2 may have written the initial MARs from prescriptions bottles brought in by clients. He would review to write orders at admission. Most clients sent medical information with currently ordered meds included. Some clients were admitted before he had a chance to review their record.
-With the former ED/RN, he was not involved in qualifying appropriate admissions. "One client brought her own meds and orders with her-she wasn't seen [by him] until the next week. Another client came in with opiates and benzos although I did not approve administration of her Oxycodone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 39 I had no say with admissions." -He was aware of 3 questionable admissions allowed by the former ED/RN. 1 client had a questionable EKG (electrocardiogram), 1 client had BMI (body mass index) less than 15 and the client with the opiate addiction. The ED/RN made all of the admission decisions without his input. Interview on 7/31/18 with new Executive Director revealed: -"Given the knowledge we have now, we know things were missed. We can't go back and change but we have corrected processes." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 123	Continued From page 40 clients (FC #4, FC #5, FC #6, FC #7). The findings are: Incident reports requested on 7/18/18 revealed only 1 incident report regarding medication on 6/20/18 for Client #2. Review on 7/31/18 of Licensee policy dated 1/1/17: Reporting of any Incidences, Unusual Occurrences or Medication Errors revealed: " ...B.POLICY: It shall be the [Licensee] practice to: *Maintain documentation of (written and digital) of errors and reactions and a written plan to address and correct/prevent these issues ... C. PROCEDURE: *Errors occurring in the medication process ..." Refer to V118 for specific errors and additional information. Interview on 7/18/18 and 8/1/18 with Nurse #2 revealed: -Staff failed to report refills timely. Once the refill request was reported she would inform the Nurse Practitioner (NP) who was then responsible for calling the pharmacy. The turnaround time could be late but usually only by 1 day. -The procedure for reporting a missed med was for staff to call the nurse. The nurse would complete an incident report. -She was not generally notified of missed medications. -She was not aware each med error required an incident report. -She was not aware that a pharmacist or physician were to be notified immediately when a client had refused or missed a medication. Interview on 7/18/18 and 7/31/18 with Corporate	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 123	Continued From page 41 Nurse (CN) revealed: -Had new processes in place already. -Had new Medication Error report form. Would be retraining staff. -Contracted pharmacy had on call availability. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 123		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 42 developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, record reviews and interview the facility failed to operate within the scope of their license where the primary purpose of services is the care and rehabilitation of	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 43	V 289		

individuals who have mental illness, a developmental disability or substance abuse disorders effecting 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former clients (FC #4, FC #5, FC #6, FC #7). The findings are:

Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V107) Based on record review and interviews, the facility failed to retain a signed job description for each staff position specifying minimum level of education, competency, work experience along with duties and responsibilities of the position for 3 of 5 current staff (Behavioral Health Technician (BHT) #1, BHT #3, Nurse #2) and 1 of 1 former staff (former Therapist #1).

Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) Based on record review and interviews, the facility failed to provide training to meet the mh/dd/sa needs of each client as specified in their treatment plans for 5 of 5 current staff (Behavioral Health Technician (BHT) #1, BHT #2, BHT #3, BHT Supervisor, Nurse #2).

Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record reviews and interviews 2 of 2 former Qualified Professionals (former Executive Director/Registered Nurse (ED/RN) and former Therapist #1) failed to demonstrate knowledge, skills and abilities required by the population served.

Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110). Based on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 44 record review and interviews the facility failed to ensure that 1 of 4 paraprofessionals (Behavioral Health Technician #1) demonstrated knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112) Based on record review and interviews the facility failed to develop and implement strategies to address the behaviors effecting 1 of 1 former clients (FC #6). Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) Based on record review and interviews, the facility failed to keep the MAR current, failed to follow the written order of a physician, failed to verify documentation of physician orders and failed to demonstrate competency affecting 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former clients (FC #4, FC #5, FC #6, FC #7). Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V123) Based on record review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former clients (FC #4, FC #5, FC #6, FC #7). Cross Reference: 10A NCAC 27G .0603 INCIDENCE 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 I or level II incidents affecting 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former Clients (#4, #5,	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 45 #6, #7). Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536) Based on record review and interviews the facility failed to ensure 4 of 6 sampled staff (Behavioral Health Technician (BHT) #2, BHT #3, BHT Supervisor and Nurse #2) had training in the use of alternatives to restrictive interventions prior to providing services. Review on 8/1/18 of Plan of Protection signed by the Executive Director on 8/1/18 revealed: "Plan of Protection for Tapestry Residential, Brevard As part of the restructuring of Tapestry as a whole, we began to implement all of these corrections on 7/1/18. The process of retraining staff and implementing appropriate systems of care/ policies and procedures has been an ongoing process for Tapestry. The organization is aware of areas of need and is actively engaged in a comprehensive internal audit to increase clinical effectiveness and staff supervision and support. Please find the current corrective measures and plans for protection below. 27G. 5601 Scope (289) -Reorganization of structure of program to address need for systemic changes associated with policies and procedures and staff development and supervision. -New Executive Director due to failure of previous Executive Director to perform job duties and adhere to expectation. -New Executive Director and Vice President of Operations met with staff to address changes in organizational structure, treatment philosophy, and implementation of new systems on 7/3/18.	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 46 -Met with current Program Director to address needs for increased supervision and adherence to policies and procedures 7/5/18. This supervision occurs on a daily basis. (Vice President of Operations and Executive Director). -Retraining of Program Director to act as Site Coordinator for monitoring operations and staff development in Brevard. -Met with Nurse Practitioner to address issues associated with MD orders, documentation, and medical management on 7/25/18. New management team is in the process of developing medical plan/ personnel development to effectively address medication management needs. -Met with therapists to address clinical expectations regarding admissions, treatment planning, individual and family therapy, aftercare planning, outpatient treatment team consultation, safety assessment and planning, timely, appropriate documentation, treatment team consultation (i.e., case conceptualization and client specific treatment planning and intervention, multidisciplinary team communication and treatment) on 7/27/18; 7/31/18; in process, and weekly in treatment team meetings starting on 7/10/18. -Implemented structured treatment team meetings to address client specific, multidisciplinary needs of each client for comprehensive care and team communication and treatment planning on 7/10/18. -In treatment team meeting, implemented client specific training for eating disorder and co-occurring conditions as it relates to treatment planning, interventions, family therapy, aftercare coordination, and case management on 7/10, 7/24. -Met/ in process of meeting with each employee to review job description, discuss job	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 47 expectations, and develop individualized professional development plans. Will be complete by 8/7/18. -In the process of hiring RN, Clinical Director, therapist (LCSW or LPC) and Site Coordinator to address needs for improved medical management, clinical services, and supervision. -Retrained/ trained on reporting of medical errors, incident reports, medical monitoring, and clinical needs for reporting for each incident. -Retrained/ trained medical management staff on medication administration, medical documentation, medical monitoring, and nursing documentation and transcription, medication pass, medication errors, accountability for medication requirements 7/18/18. 27G0109e Medication Requirements Immediate Corrective Measures/Describe Your Plans to Make Sure the Above Happens: -All staff have completed a medication administration class by state approved trainer (pharmacist or RN) by 8/1/18. -Retrained nurse on the use and need for physician orders for all client medications, the need for self -administration medication physician order for all clients, medication storage and management of medical supplies, appropriate use and management of comprehensive medication administration record, medical documentation, and use and management of scheduled drugs within the facility as of 8/1/18. -Job offer for new RN went out as of 8/1/18. -All staff/ Behavioral Health Technicians (BHT) are trained on assisting the nurse with the above as of 8/1/18. -Development of a Nurses' House Assessment to monitor and increased accountability for medical management including availability/ prescription management, orders, documentation, and storage. Assessment in effect as of 8/1/18 and	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 48 monitored by the current Program Director. -Developed a Medication Administration Observation Form to assist in ongoing training and development of medication management skills for BHT as of 8/1/18 (monitors technique, storage, communication). Monitored by Program Nurse. -Routine observations and supervision on each shift to ensure compliance with medication management protocol as of 8/1/18. Monitored by Program Nurse. -Developed a new procedure for medication errors that includes report to nurse as soon as error is discovered. Nurse then reports to physician for follow up plan. All medication errors are documented on Medical Error form. Effective 7/18/18. Monitored by Program Nurse. -Staff were retrained on medication errors and reporting on 7/18/18 by Program Nurse. -Nurse will be supervised by Executive Director and will attend monthly medical meeting at Pyramid HQ for increased supervision and medical consultation. 27G.0207 Treatment Plan (112) Immediate Corrective Measures/ Describe Your Plans to Make Sure the Above Happens: -All staff will be trained on client specific treatment planning to address biopsychosocial needs and safety needs in a timely manner (by 8/7/18) (Executive Director will be responsible for oversite until hire of Clinical Director). -All staff will be trained on appropriate observation and intervention within their professional scope for self harm and safety issues. Ongoing observation of self harm/safety needs and assessment of previous self harm/safety history will be emphasized and addressed (by 8/7/18) (Program Nurse and Executive Director will be responsible for	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 49 oversite) -Safety Plans will include client driven intervention and staff plans for intervention and monitoring of safety plan (as opposed to client ideas for safety plan) -Training and development of client specific biopsychosocial treatment planning and intervention for each client will be addressed. (Executive Director will be responsible for oversite until hire of Clinical Director). (Training process began on 7/29/18 and will be complete by 8/7/18). -Training on effective multidisciplinary treatment team consultation will occur to address appropriate treatment planning discussion to best meet client specific needs. This is ongoing weekly training that began on 7/10/18. 27G0202 a&g Personnel Requirements (107, 108) Immediate Corrective Measure -As a result of change in leadership, all current employees are meeting with new Executive Director to review job expectations and sign up to date job descriptions. This will occur by 8/7/18. -All staff will be trained in the following: -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 have attended. -CPR/First Aide/NCI Trainings for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18. Describe Your Plans to Make Sure the Above Happens:	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 50 -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. -Executive Director (until hire of Site Coordinator) will monitor new hire compliance with specific trainings and will develop plans for lapses in training for all current employees. Employees that have not received appropriate training will not be permitted to work until training is complete. -Executive Director reviewed personnel files with HR Director on 7/29/18 to ensure compliance with this process. Plans for specific staff training needs were developed. 27G.0604 Incident Reporting Requirements	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 51 Immediate Corrective Measures: -CQI Director provided 1 hour training for all incident reporting requirements for current employees on July 13h and 17th at 1pm. All employees attended one of the trainings. -Documentation of Incident Reporting Training is maintained in employee personnel file and was reviewed on 7/29/17 by Executive Director and Regional HR Director. Describe Your Plans to Make Sure the Above Happens: -All staff have been trained on all levels of incident reporting including medication errors. Staff are trained as of 8/1/18 on how to report incidents and the importance communication of incidents to appropriate personnel for medical management and follow up. -CQI Director will provide 1 hour training for all new 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. -It is the responsibility of Executive Director (until hire of Site Coordinator) to oversee the Incident Reporting Training. All employees that receive training will receive documentation of the curriculum covered within the training. Each	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 52	V 289		

training certificate will include summary of the curriculum covered, date and time of the training, signatures of the employee, CQI Director, Site Coordinator, 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.
27G. 0203 Competencies of Qualified Professionals; 27G 0203 Competencies and Supervision of Paraprofessionals
Immediate Corrective Measures
-Tapestry Brevard is in the process of reorganization of personnel and treatment structure.
-New Executive Director as of 7/1/18.
-Plans for reorganization of leadership structure in Brevard for an onsite Site Coordinator to ensure appropriate operations and client care.
-Job offer out to new RN with a start date of 9/1/18.
-Job posting for Clinical Director, Site Coordinator, and fully licensed therapist.
-Executive Director and current Program Director will oversee QP staff on site until hire of Clinical Director.
-Current Program Director is onsite daily as on 7/31/18 to oversee QP operations and effective delivery of treatment services.
-Therapists attend monthly Certification of Eating Disorder Specialist (CEDS) Training on a monthly basis beginning in June.
-Therapist will engage in treatment planning for each client with specific strategies for client needs including biopsychosocial needs, self harm, and SI. (Executive Director will monitor this process until hire of Clinical Director).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 53 Describe Your Plans to Make Sure the Above Happens: -Weekly, multidisciplinary treatment team to ensure appropriate delivery of services. Treatment team meetings occur on Tuesdays at 9am. Current Program Director will take meeting minutes and report to all staff prior to new hire of Site Coordinator. -RN/ LPN will attend Medical Meeting at Pyramid HQ on a monthly basis with next meeting scheduled for 8/8/18 and then the 3rd Wednesday of every month moving forward." FC #6 was readmitted to the facility in April 2018 after 4 months of psychiatric hospitalization. Her prior placement at Tapestry had ended in September 2017 following an episode of self-harm when she ingested fabric softener and subsequently eloped from the facility. Her self-harm was as recent as 1-2 weeks prior to her readmission into the program. The facility, with full knowledge of her history, failed to develop and implement strategies to address her self-harm and suicidal ideation. Former Therapist #1 failed to identify goals or interventions to address self-harm in her initial treatment plan nor were interventions added later when her self-harm began to increase. The Behavior Contract written at admission by former Therapist #1 failed to outline any preventative measures put in place to prevent FC #6's access to items she could use to inflict self-harm. There was no increase in her supervision. From 4/9/18 until 5/22/18 FC #6 continued to self-harm. She scalded herself with hot water, heated mugs repeatedly in the microwave in order to use them to burn herself, and used abrasive sandpaper to scratch her skin. During that timeframe she also obtained glass, a lighter and stockpiled medications that she admitted were kept in the	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 54 event she wanted to commit suicide. On 5/15/18 she was observed to have new large burns on her wrist and then on 5/22/18 she had additional new burns on her forearm. It was not until 5/22/18 that the facility limited her access to the microwave and had a staff member monitor her use of the stove. On 5/25/18 chemicals were left unlocked in the bathroom by BHT #1. FC #6 had access to the harmful chemicals and put them into her open eye. Additionally, the facility failed to ensure that staff had a clear understanding of their job requirements and failed to ensure staff were trained in eating disorders as well as trained to meet the treatment needs of the clients served. There was no system of oversight to ensure staff reported critical incidents of self-harm or errors in medication administration. Multiple critical incidents occurred over a period of 4 months that went unreported and unaddressed. The facility transitioned to an Electronic Medication Administration Record on 6/1/18 in an already complicated electronic medical record system at the direction of the Former Executive Director/Registered Nurse. Neither the Nurse Practitioner (NP) nor the Nurse was aware doctor's orders could not be retrieved in its full form showing an electronic time stamped signature until an audit in a sister facility revealed a similar issue. There was no evidence of a secondary or back up process to catch or correct identified system problems. Paper MARs and medication orders by community doctors were uploaded to this system also without a backup plan. Based on this lack of verification of orders and MARs, Clients #1, #2, Former Clients #4, FC #5, FC #6 and FC #7 all had significant deficits in medication requirements for psychotropics, analgesics antiepileptics and vitamin/supplements.	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 289	Continued From page 55 Six clients missed 216.5 doses of 23 medications; 30 medications were given on 305 days without physician orders; 5 medications were doubled the order on 3 days; 1 medication was administered at a higher dose for 31 days and no MAR was available for 25 medications covering 31 days as outlined in report. These systemic failures resulted in serious harm and neglect for Client #1, Client #2, Client #3, FC #4, FC #5, FC #6 and FC #7 and constitute a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of $ 2000 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 289		
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;	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 56 (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 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;	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 57 (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 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.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 58 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 I or level II incidents affecting 2 of 3 current clients (Client #1, Client #2) and 4 of 4 former Clients (FC #4, #5, #6, #7). The findings are: Review on 7/19/18 of incidents reports from 4/1/8-7/19/18 revealed: -The only incident of self-harm for FC #6 documented was on 5/25/18. -No other incidents for self-harm were documented for FC #6 although observed by the Nurse Practitioner. -One report was completed for a medication error for Client #2. -No additional incident reports were documented for errors in medication administration. Review on 7/31/18 of Licensee policy dated 11/15/18: Critical Incidents Procedure revealed: " ...B. POLICY: It will be the [Licensee] practice to work aggressively to prevent behaviors and/or situations which experience and expertise indicate might lead to Critical Incidents. When such incidents nonetheless do occur, it will be the practice to address Critical Incidents immediately, working to de-escalate an incident, taking preventative active to prevent future Critical Incidents and documenting the incident so that there is a permanent record that can be both referred to and learned from. This will be followed by a written analysis of each Critical Incident, to be conducted by the Executive Director. On-going training in prevention, de-escalation and documentation will be	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 59 conducted. C. PROCEDURE: A Critical Incident is defined as any occurrence of unusual behavior that poses a risk to self or others, creates hostile or unsafe working environment for Staff or clients and involves a client and/or staff. An incident review form is completed within 12 hours of awareness of the incidents by Staff involved with or witnessing the Critical Incident. Staff will be debriefed by management in order to determine any changes that are required in the [Licensee] physical plant, process or procedure that may have been a contributing factor in the incident. [Licensee] management staff will review all incident forms within 24 hours of the incident and after debriefing, will document [Licensee] response to the incident which may include staff retraining, process and procedure changes, clinical treatment plan or service delivery changes if a higher level of care or additional coordination is needed. Incident review forms will be kept confidential and will be filed with the Operation Director ..." Record review on 7/31/18 for Former Client #6 revealed: -Admitted on 4/9/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Major Depressive Disorder, and Social Anxiety Disorder. -Discharged on 5/26/18. -Prior treatment episode in the program from July-September 2017. -" ...History of self harm ...burning ...history of suicidal ideation ...no self harm in last two weeks, suicidal ideations, no plan ..." -" ...self-harming began at 12- 7th grade- cutter, 8th grade added in burning-burned through high school-pick wounds open-infect them, make them as painful as possible, In psych wards I will	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 60 scratch or hit my head when I don't have access to sharps ..." Review on 7/31/18 of the psychiatric follow up notes completed by the NP revealed: -On 5/15/18 " ...she (FC #6) told staff on 5/12 that she has been thinking of burning herself on hot water kettle so it was taken away but she now admits that she had already burned herself at that point. She has 2 large (1-2") blisters on her R (right) wrist from this ..." -On 5/22/18 "[FC #6] has several new, large burns on her R forearm adjacent to those seen last week. In the absence of a hot kettle (see 5/15 note) she has taken to overcooking hot water for tea in the microwave and burning herself on the lip of the mug ..." Review on 7/19/18 of the June 2018 and July 2018 MARs (medication administration records) and physician orders for Client #1 revealed: -Three medications were not documented as administered per the physician's order. -The dosage amount for 7 medications was not documented. Review on 7/19/18 of the May 2018 and June 2018 MARs (medication administration records) and physician orders for Client #2 revealed: -Thirteen medications were administered for 23 days without physician orders. -Four medications were administered twice on 6/1/18. Review on 7/19/18 of the April 2018 and May 2018 MARs (medication administration records) and physician orders for FC #4 revealed: -Four medications were not documented as administered per the physicians order. -Wellbutrin was administered for 34 days without	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 61 a physician's order. Review on 7/19/18 of the April 2018 and May 2018 MARs (medication administration records) and physician orders for FC #5 revealed: -Two medications had no physician's orders. -Ten medications were not documented as administered per the physician's order. Review on 7/19/18 of the April 2018 and May 2018 MARs (medication administration records) and physician orders for FC #6 revealed: -Four medications had no physician's orders. Review on 7/19/18 of the April 2018 and May 2018 MARs (medication administration records) and physician orders for FC #7 revealed: -Eleven medications had no physician's orders. Interview on 7/31/18 with Behavior Health Technician (BHT) #1 revealed: -There had been times that the medications ran out for clients. She indicated that the refill orders were not written in a timely manner and subsequently not called in timely. -She stated that Former Client #6 (FC #6) went four days without her medication for her mental health disorder. She indicated that other clients had also gone periods of time without their medications refilled but could not specify who, timeframe, or medication. -There were other incidents of self-harm prior to the incident on 5/25/18. Interview on 7/19/18 with BHT #3 revealed: -She indicated one client who missed a medication for one night during July because the refill had not been delivered by the pharmacy. The medication arrived the next day.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 366	Continued From page 62 Interview on 7/19/18 with BHT #2 revealed: -She indicated that medications had run out "a lot of times". -She indicated there were incidents when clients went "several days to a week" without medications. -She stated that at admission it typically took a few days to get the medications started for the clients. -FC #6 had run out of her anti-depressant but it did come late "after much advocacy". Interview on 8/1/18 with the Executive Director revealed: -All internal level I or level II incidents were required to be documented. -Any self-harm that occurred was to be documented. The need to document any incidents of self-harm was even greater with FC #6 due to her history. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 366		
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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 536	Continued From page 63 other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 536	Continued From page 64 escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the 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:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 536	Continued From page 65 (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 536	Continued From page 66	V 536		

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to ensure 4 of 6 sampled staff (Behavioral Health Technician (BHT) #2, BHT #3, BHT Supervisor and Nurse #2) had training in the use of alternatives to restrictive interventions prior to providing services. The findings are:

Record review on 7/19/18 for BHT #2 revealed:
-Date of Hire was 12/10/17.
-Documentation of training in alternatives to restrictive interventions was dated 1/16/18 after date of hire.

Record review on 7/19/18 for BHT #3 revealed:
-Date of Hire was 5/14/18.
-Documentation of training in alternatives to restrictive interventions was dated 6/21/18 after date of hire.

Record review on 7/19/18 for BHT Supervisor revealed:
-Date of Hire was 4/30/18.
-Documentation of training in alternatives to restrictive interventions was dated 7/12/18 after date of hire.

Record review on 7/19/18 for Nurse #2 revealed:
-Date of Hire was 3/26/18.
-Documentation of training in alternatives to restrictive interventions was dated 6/14/18 after date of hire.

Interview on 7/19/18 with Human Resources Director revealed:
-She thought the training in alternatives to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-023	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

(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 536	Continued From page 67 restrictive interventions was allowed to be completed within 90 days of hire. She was not aware it was required prior to providing services. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days.	V 536		