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	DHSR - Mental Health SEP 11 2018 Lic. & Cert. Section	
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		

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

8/3/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		

Plan of Corrections for Tapestry Residential, Brevard

27G. 5601 Scope (289)

Plan of Protection:

- 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 on 7/1/18.
    - 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.
    - Hired Site Coordinator to address needs for increased supervision and adherence to policies and procedures effective 8/13/18. This supervision occurs on a daily basis. (Executive Director is responsible for oversite).
    - Met with Nurse Practitioner to address issues associated with MD orders, documentation, and medical management on 7/25/18.
    - New medication administration and management protocols in effect as of 8/1/18. Responsibility of oversite is the Program RN.
    - 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). 7/27/18; 7/31/18.
        - Oversite is the responsibility of the Executive Director until the new Clinical Director is hired on 11/5/18. Weekly individual supervision sessions and weekly treatment team meetings are conducted by Executive Director with each therapist and multidisciplinary treatment team.
    - Implemented structured treatment team meetings to address client specific, multidisciplinary needs of each client for comprehensive care and team communication and treatment planning.
        - Occurs every week, oversite is the responsibility of the Executive Director.
    - Met with each employee to review job description, discuss job expectations, and develop individualized professional development plans- Completed 8/18/18.
    - In the process of hiring Clinical Director (start date 11/5/18) and therapist (LCSW or LPC).
    - In the process of transitioning from medical services of Dr. Buie to medical supervision under Dr. Schroer for improved medical management.
    - All staff that manage medication are trained in medical errors, incident reports, medical monitoring, and clinical needs for reporting for each client.
        - Monthly medical meetings that occur third Wednesday of every month at 12pm. Oversite is the responsibility of the Medical Director.
    - Retrained medical management staff on medication administration, medical documentation, medical monitoring, and nursing documentation and transcription, medication pass, medication errors, accountability for medication requirements.

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 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.

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

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

Corrective Measures:

- Program Director to meet with Therapists and review PCP and treatment plans to ensure Goals and Expectations are clearly documented and addressed. Program Director reviewed current cases for strategies/treatment goals/safety plans on 6/18/18.
- Program Director scheduled Clinical Training Review with Therapists on 6/18/18 at 12:00 pm at Fletcher Location to review procedure for Assessment Review, PCP requirements and Treatment Planning Review.
- Safety Protocol Form developed on 6/18/18.
- Prescreen is completed for each potential client by the Immediate Response Team Call Center.
- IRT will collect the following information for each client:
    - Presenting problem
    - Needs and strengths
    - Provisional Diagnosis (to be established by reviewing clinician)
    - Pertinent social, family, and medical history
    - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current

medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
    - Completed Medical Form for each potential client including comprehensive lab results within the last 14 days and EKG.
    - Clinical record of previous and current treatment episodes and outpatient treatment providers.
- Prescreen is reviewed within 24 hours by Program Nurse, Program Director or Executive Director, and MD.
- Program Director or Nurse contact client and family member of potential client to assess for the following within 24 hours of completion of the prescreen:
    - Presenting problem associated with eating disorder symptoms and co-occurring conditions
    - Needs and strengths
    - Provisional Diagnosis
    - Pertinent social, family, and medical history
    - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
- Family Screening call will be documented in eCR in Progress Note (Memo to Chart)
- Program Director, Executive Director, Nurse, and MD review potential client details with treatment team including RDs and clinicians within 48 hours of the initial prescreen.
- If client is deemed psychiatrically and medically appropriate for admission and the clinical team assesses that the client will benefit from Tapestry services, admission details will be confirmed.

- On the day of admission, clinician facilitates biopsychosocial assessment to assess for the following:
    - Presenting problem associated with eating disorder symptoms and co-occurring conditions
    - Needs and strengths
    - Provisional Diagnosis
    - Pertinent social, family, and medical history
    - Pertinent assessment of the following: historical and current psychiatric symptoms; historical and current substance use/ abuse; historical and current medical history; any other historical or current assessment needed after reviewing nature of presenting problem.
- Clinician completes treatment plan addressing the following areas:
    - Anticipated client outcome(s) from services provided and projected date of achievement.
    - Clinical strategies to address each presenting concern associated with eating disorder symptomology and co-occurring conditions.
    - Treatment team providers (staff) responsible for providing clinical services.
    - Schedule for Treatment Plan updates with client and guardian.
    - Outline of objective measures to assess for efficacy of treatment plan for each presenting issue.
    - Written consent from client and guardian for treatment plan for client.

- Clinical treatment team will review new admissions in weekly multidisciplinary treatment team meetings.
- Any safety issues noted in the prescreen will be communicated to the treatment team by the Program Director prior to admission.
    - A safety plan will be developed by the clinician prior to admission if there is any history of self harm or suicidal ideation noted in the prescreen or family prescreen.
    - The safety plan will be reviewed in a treatment team meeting facilitated by the Program Director and uploaded into the eCR for all clinical staff to access.
    - The safety plan will be reviewed with the client and guardian prior to admission and again at the time of admission.
    - Client safety will be assessed on a daily basis by clinician and recorded in daily progress note in the eCR.
    - Safety Plan Document will be available in eCR on 8/1/2018. Hard copies of Safety Plan will be used prior to this time and effective immediately as of 7/1/18.
- Clinical Program Requirements will be distributed to staff to ensure treatment team member awareness of expectations on 7/25/18. Clinical Program Protocol includes the following:
    - 2 individual sessions per week with therapist and client with documentation the day the service is provided.
    - 1 family session per week therapist, family member/ supportive person, and client with documentation the day the service is provided.
    - Comprehensive Treatment Plan within 24 hours of admission with weekly treatment plan updates
    - Medication management and MD consultation 1 x weekly for each client with documentation the day the service is provided.
    - PRN Nursing Services with 24 hour on call nursing staff
    - Daily psychotherapeutic process group with documentation the day the service is provided.
    - Daily psychoeducational group with topics pertinent to eating disorders and co-occurring conditions with documentation the day the service is provided.
    - Nutritional assessment within 24 hours of admission with RD and client with documentation the day the service is provided.
    - Weekly individual nutritional consult with RD with documentation the day the service is provided.
    - Daily nutritional groups and monitored meals with documentation the day the service is provided.
- Each current qualified professional will meet with Program Director and Executive Director to establish individualized supervision plan to occur on a routine basis to ensure appropriate, effective facilitation of treatment services.
    - Documentation of initial meeting and supervision plan will be stored in employee personnel file.
    - All employee supervision plans will be completed by 7/27/18 and stored in personnel file.
- Addition of training for Clinical Integrated Treatment for Trauma and Eating Disorders
    - All current staff will complete the training in My Learning Pointe by 8/26/18.
    - All new hires will complete the training as part of their initial training within the first 72 hours of their start date.

    - There will be an evaluation of competency for each participant that completes the training.
- Scheduled Acceptance and Commitment Therapy Training on 9/20/18 and 9/21/18 for treatment of eating disorders, trauma, substance use, and co-occurring conditions.

Compliance and Prevention:

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

Monitoring:

- It is the responsibility of the Site Coordinator to review each admission to assess for compliance to this policy
- It is the responsibility of the Site Coordinator to conduct weekly chart audits on all charts to ensure compliance with this policy. Site Coordinator will keep a record of weekly audits.
    - All current charts will be audited by Program Director as of 8/26/18.
- Individual Employee Supervision Plans will be reviewed by employee, Site Coordinator, and Executive Director in conjunction with annual and semi-annual performance evaluations to monitor effectiveness and assess for continued needs.
- Sit Coordinator and Executive Director will meet weekly to discuss ongoing training needs for staff to ensure continued application of evidence based treatment interventions for clients with eating disorders, trauma, substance use, and co-occurring conditions.

27G0209 Medication Requirements

Plan of Protection
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 with start date of 9/4/18.
    - 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 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 8/15/18. Monitored by Program Nurse.
    - Staff were retrained on medication errors and reporting on 8/18/18 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.

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

- RN/ Executive Director is no longer working for the organization and new leadership is established in the program.
- Effective immediately, all medications, including standing orders, will only be dispensed with MD order.
    - Program Nurse, in consultation with program MD, developed medical records with medical notes, medical orders, and initial evaluations.
    - All copies of orders will be uploaded into Carelogic and stored in the Document Library of the eCR in addition to the paper copy located in the medical chart.
- All staff involved in medication administration will be trained in medication administration by state standards and program/ facility. No untrained staff will provide med services.
    - New RN started on 9/4/18.
- Tapestry nursing staff will ensure that medications provided for clients will only be dispensed with an order from a person authorized to prescribe medications by State of North Carolina.
- All current staff will be trained in medication administration by Blue Ridge Pharmacy or RN. All new hires will be fully trained by an authorized medication administration trainer prior to providing client services associated with medications.
- All staff will be retrained in state approved medication administration on an annual basis.
- Development of a new MAR system to ensure the following:
    - Client's name
    - Name, strength, and quantity of the drug
    - Instructions for the administering the drug
    - Date and time of the administration of the drug
    - Name or initials of person administering the drug
- Development of system for management of medical records to ensure competent review of medical orders

- Medication orders will be reviewed immediately following MD visits.

Compliance and Prevention:

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

Monitoring:

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

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

Deficiencies were failure to ensure appropriate staff training.

Plan of Protection:

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.
- 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.

Corrective Measures:

- As a result of the deficiencies cited above, all staff will be trained in the following by 8/26/18:
    - CPR and First Aid
    - NCI
    - Eating Disorder and Trauma Specific Treatment
    - Mental Health Treatment
    - Substance Use Disorder Treatment
    - Incident Response and Reporting training is scheduled for 7/13/18 and 7/17/18. All staff will attend.

- CPR/First Aide/NCI Trainings for all staff required on 6/13/18, 6/14/18, 6/21/18 and 6/27/18.
- As a result of deficiencies cited above, management of the Personnel Files was moved to the Regional HR Director as of 7/10/18. Personnel Files will be maintained by Director of Human Resources and will include:
    - Up to date job description signed by staff member and supervisor
        - Minimum level of education
        - Competency

    - Work experience
    - Duties and responsibilities of position
- Evidence of all training for employee, verification of licenses, certifications, and other qualifications.
- Documentation of all continuing education
- Documentation/ Evidence of:
    - New Employee Orientation
    - Client Rights and Confidentiality (10A NCAC 27C, 27D, 27E, 27F, and 10 NCAC 26B)
    - Specific Eating Disorder, Trauma Related Disorders, and Co-occurring Conditions Training for each Tapestry employee.
    - Infections Disease and Blood Borne Pathogen Training
    - First Aid and CPR certification
- All staff members will be trained in Basic First Aid (including seizure management)
- All staff members will receive in person CPR training by the Red Cross, American Heart Association, or their equivalency.

Compliance and Prevention

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

Monitoring

- Program Director will monitor new hire compliance with specific trainings.
- Executive Director and Regional HR Director will review personnel files for all new hires after 60 days of employment to ensure compliance.
- All new hire training is expected to be completed or scheduled at 60 days of employment.
- As a result of the deficiencies stated above, Executive Director and Vice President of Operations will meet and review personnel files with HR Director on 7/29/18 to ensure compliance with this correction.

27G.0604 Incident Reporting Requirements

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.

Prevention and Monitoring:

- 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 Site Coordinator to oversee the Incident Reporting Training. All employees that receive training will receive documentation of the curriculum covered within the training. Each training certificate will include summary of the curriculum covered, date and time of the training, signatures of the employee, CQI Director, 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. Effective 8/13/18.
    - Job offer out to new RN with a start date of 9/1/18. Start date of 9/4/18.
    - 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.
- Site Coordinator is onsite daily as on 8/13/18 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.

Prevention and Monitoring

- Weekly, multidisciplinary treatment team to ensure appropriate delivery of services. Treatment team meetings occur on Tuesdays at 9am. Oversite is the responsibility of the 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.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

August 27, 2018

DHSR - Mental Health
SEP 11 2018
Lic. & Cert. Section

Jessie Alexander, Executive Director
Appalachian Outpatient Services, LLC
11 North Country Club Road
Brevard, NC 28712

Re: Complaint Survey completed August 3, 2018
Tapestry Eating Disorder Program, 11 North Country Club Road, Brevard, NC 28712
MHL # 088-023
E-mail Address: jalexander@silverridgerecovery.com
(Complaint Intake #NC139623, NC139701, NC139773)

Dear Ms. Alexander:

Thank you for the cooperation and courtesy extended during the complaint survey completed 8/3/18. The complaints were substantiated.

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

Type of Deficiencies Found

- Type A1 rule violation(s) are cited for: 10A NCAC 27G .5601(V289) Scope with Cross Referenced: 10A NCAC 27G .0202 Personnel Requirements (V107); 10A NCAC 27G .0202 Personnel Requirements (V108); 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals; 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110); 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan; 10A NCAC 27G .0209 Medication Requirements (V118); 10A NCAC 27G .0209 Medication Requirements (V123); 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366) and 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions.

Time Frames for Compliance

- Type A1 violations and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is 8/26/18 Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Appalachian Outpatient Services, LLC for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

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

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

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Robin Sulfridge, Branch Manager at 336-861-7342.

Sincerely,

Cathy Samford
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
File