Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	R 01/30/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 1/30/19. The complaint was unsubstantiated (Intake #NC00146461). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	V 000	A new plan and paper work have been put in place for Fire and Disaster drills. This plan will be monitored monthly by Regional Maintenance and Tapestry staff to ensure that all Drills are conducted on all shifts (1st, 2nd and 3rd) quarterly, meeting state requirements. Client participation will also be a focus area as these drills are conducted. Fire and Disaster plans are in place for all staff to review so drills are conducted properly. These books have been approved by local authorities. Drills have already begun.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills quarterly on each shift. The findings are: Review on 1/30/19 of the fire and disaster drills for 7/2018-12/2018 revealed: -No first or second shift fire or disaster drill for 7/2018-9/2018.	V 114		

DHSR - Mental Health
MAR 05 2019
Lic. & Cert. Section

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V 114	Continued From page 1 -No second shift fire or disaster drill document for 10/2018-12/2018. Interview on 1/30/19 with the Maintenance Manager revealed: -He took over management of the fire and disaster drills in October 2018. -The facility operated with 2 shifts. -He was unable to locate any drills conducted before October 2018. -He had not conducted any drills on the 2nd shift.	V 114		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL045-133 Y1	A. Building B. Wing Y2	1/30/2019 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0108	Correction	ID Prefix V0109	Correction	ID Prefix V0111	Correction
Reg. # 27G .0202 (F-I)	Completed	Reg. # 27G .0203	Completed	Reg. # 27G .0205 (A-B)	Completed
LSC	01/30/2019	LSC	08/20/2018	LSC	08/20/2018
ID Prefix V0118	Correction	ID Prefix V0179	Correction	ID Prefix V0366	Correction
Reg. # 27G .0209 (C)	Completed	Reg. # 27G .1301	Completed	Reg. # 27G .0603	Completed
LSC	08/20/2018	LSC	08/20/2018	LSC	08/20/2018
ID Prefix V0367	Correction	ID Prefix V0536	Correction	ID Prefix	Correction
Reg. # 27G .0604	Completed	Reg. # 27E .0107	Completed	Reg. #	Completed
LSC	08/20/2018	LSC	08/20/2018	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Sherry Waters	DATE 2/7/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/14/2018	☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

February 11, 2019

Chad Husted, VP of Operations
Appalachian Outpatient Services, LLC
270 Lakemont Park Blvd
Altoona, PA 16602

Re: Annual, Follow up and Complaint Survey completed 1/30/19
Tapestry Adolescent Residential Program, 5030 Hendersonville Rd, Fletcher, NC 28732
MHL # 045-133
E-mail Address: eevans@pyramidhc.com; jalexander@pyramidc.com
(Intake #NC00146461)

Dear Mr. Husted:

Thank you for the cooperation and courtesy extended during the annual, follow up and complaint survey completed 1/30/19. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 3/31/19.

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,

Sherry Waters

Sherry Waters
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: dhhs@vayahealth.com
qmemail@cardinalinnovatins.org
File