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
	MHL088-023	A. BUILDING: _____ B. WING _____	R 04/24/2019

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 An annual and follow up survey was completed on 4/24/19. A deficiency was cited. This faciltiy is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Individuals of all Disability Groups/Mental Illness and 10A NCAC 27G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill.	V 000	DHSR - Mental Health MAY 16 2019 Lic. & Cert. Section	
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	V 118		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jesse Kercorke TITLE Executive Director (X6) DATE 5/7/19

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V 118	Continued From page 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure prescription drugs were available to be administered as ordered by the physician for 1 of 2 sampled clients (#1). The findings are: Observation on 4/23/19 at 2:00pm of the medications for Client #1 included: -Ventolin HFA inhaler 2 puffs 3 times a day as needed, dispensed on 4/23/19. Review on 4/23/19 of the record for Client #1 revealed: -Admission date of 4/12/19 with diagnoses of Anorexia Nervosa, restricting type, Generalized Anxiety Disorder, Major Depressive Disorder, Dissociative Identity Disorder, Social Anxiety Disorder, Post-Traumatic Stress Disorder and Unspecified Insomnia. -Physician order dated 4/23/19 for Ventolin HFA inhaler 2 puffs 3 times a day as needed, may keep at bedside. Interview on 4/23/19 with Client #1 revealed: -She had her old inhaler with her today, but did not realize it was expired and received a new inhaler. -She had no concerns regarding medications. Interview on 4/23/19 with the Registered Nurse revealed:	V 118		

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TAPESTRY EATING DISORDER PROGRAM	11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712

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V 118	Continued From page 2 -He had just been working alone for 1 week and this was his 2nd day in this facility. -The old inhaler for Client #1 was expired and a new one was obtained today. -The client came to the facility with the inhaler and he did not do the intake upon admission. -His procedure would be to triple check the date filled for medications to ensure they were not expired on the day of admission.	V 118	Program Nurse will check all medications at time of admission to ensure that all state and CARF requirements are followed for medication with no expired meds. Site Coordinator will double check after Program Nurse has completed Admission Protocol for medications. Program Nurse will check all medications routinely and in a timely manner to ensure that all medications are not expired and in accordance with medical orders. Oversite of this policy is the responsibility of the Site Coordinator.	4/23/19 and ongoing

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
MHL088-023	A. Building B. Wing	4/24/2019

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

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 V0123 Reg. # 27G .0209 (H) LSC	Correction Completed 04/24/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Sherry Waters	DATE 4/26/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/4/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL088-023 (Y1)	A. Building B. Wing (Y2)	4/24/2019 (Y3)

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

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 V0131 Reg. # G.S. 131E-256 (D2) LSC	Correction Completed 04/24/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Sherry Waters	DATE 4/26/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/7/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: X4TT12

STATE FORM: REVISIT REPORT (11/06)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

April 30, 2019

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

Re: Annual and Follow up Survey completed 4/24/19
Tapestry Eating Disorder Program, 11 North Country Club Road, Brevard, NC 28712
MHL #088-023
E-mail Address: jalexander@pyramidhc.com

Dear Ms. Alexander:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 4/24/19.

As a result of the follow up survey, it was determined that some 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

- Re-cited standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 5/24/19.

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.

April 30, 2019
Jessie Alexander
Appalachian Outpatient Services, LLC

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 Sonia Eldridge, Team Leader at 828-665-9911.

Sincerely,

Sherry Waters

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

Cc: qmemail@cardinalinnovations.org
dhhs@vayahealth.com