STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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

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V 000	INITIAL COMMENTS A complaint survey was completed 3/22/21. The complaints, intake # NC174129 and # NC174503 were substantiated and # NC174144 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.	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. (c) All facilities or services shall require that all applicants for employment disclose any criminal	V 107	DHSR - Mental Health APR 28 2021 Lic. & Cert. Section	

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
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V 107	Continued From page 1 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 ensure that a file was maintained for each individual employee for 10 of 10 Contracted Personnel (CP #5, #6, #7, #8, #9, #10, #11, #12, #13, #14). The findings are: Review on 3/4/21 of contract between the Licensee and local personnel agencies revealed: -Local Personnel Agency A contract revealed: " ... [parent company for Licensee] will determine scope and duration of personnel's activities, to be conducted pursuant to the plan of care ..." -" ...[parent company for Licensee] will provide to [Personnel Agency #1] personnel orientation with regard to Facility policy and procedure, EMR (electronic medical record) system, and instruction in keeping necessary records as	V 107	**POC:** Tapestry Executive Leadership (Executive Director and Executive VP of Operations) Executive Director will maintain personnel files for all site employees including all contract employees. Executive Director will be responsible for ensuring that all contract agency employees have had all necessary trainings prior to starting at facility. Executive Director and Director of Performance Improvement will conduct monthly training audits to ensure compliance to the rule. Executive Clinical and Compliance Leadership (Executive Director, Director of Performance Improvement, and VP of Clinical Services and QM will conduct monthly audits and review to ensure compliance to the rules.	

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V 107	Continued From page 2 requested by the Facility ..." -" ...[Personnel Agency #1] shall provide in-service education to personnel annually based upon the needs mutually identified by [Personnel Agency #1] and [parent company for Licensee]. [Personnel Agency #1] shall comply with the North Carolina Department of Health and Human Services regulations for qualification and continuing education of staff." -Local Personnel Agency #2 contract revealed: " ...It shall be the responsibility of Customer [Appalachian Outpatient Services DBA Tapestry Eating Disorder Program] to provide Provider [Personnel Agency #2] personnel with Customer and Customer facility orientation ..." -" ...Customer [Appalachian Outpatient Services DBA Tapestry Eating Disorder Program] shall allow Provider [Personnel Agency #2] supplemental personnel to attend appropriate Customer staff development programs as required for assignment ..." Review on 3/3/21 of CP billing summary revealed: -CP #5 first day of work at facility was on 2/19/21 -CP #6 first day of work at facility was on 2/19/21 -CP #7 first day of work at facility was on 2/25/21 -CP #8 first day of work at facility was on 2/16/21 -CP #9 first day of work at facility was on 2/13/21 -CP #10 first day of work at facility was on 2/16/21 -CP #11 first day of work at facility was on 2/12/21 -CP #12 first day of work at facility was on 2/18/21 -CP #13 first day of work at facility was on 2/19/21 -CP #14 first day of work at facility was on 2/14/21 Interview on 3/15/21 with the Executive Director revealed:	V 107		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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

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V 107	Continued From page 3 -The personnel agencies kept the files for their employees. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule 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 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	V 108		

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V 108	Continued From page 4 clients. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that each staff were provided training on the mental health/substance abuse (MH/SA) needs as specified in the treatment habilitation plan for 8 of 10 Contracted Personnel (CP #5, #6, #8, #9, #10, #11, #13, #14). The findings are: Review on 3/15/21 of Individualized Client Treatment Forms for Clients #1, #2 and#3 revealed: -document included client name, admission date, diagnosis, presenting problem, mood/self-harm/SI (suicidal ideation), trauma, treatment history, outpatient team. -Staff #1, Staff #2 and Staff #3 as well as CP #7 and CP #12 signed the client document for Client #1, Client #2 and Client #3 although there were no dates to indicate when the trainings occurred. -3 other current non-audited client's information forms were presented and reviewed with Staff #1, Staff #2, Staff #3, CP #7 and CP #12 signatures included. -no evidence was provided to support that CP #5, CP #6, CP #8, CP #9, CP #10, CP #11, CP #13 or CP #14 received client specific training or any other training on mental health/developmental disabilities or substance abuse. Interview on 3/17/21 with CP #5 revealed: -She mostly worked 3rd shift from 11pm-7am but also worked 5pm-8 or 9pm to help with evening	V 108	**POC:** Client specific training forms completed at time of admission were edited to add target behaviors, target plan and appropriate response for behaviors, and signature dates for each direct care staff member. Clinical Director will be responsible for writing client specific trainings at time of admission and editing/ refining client specific training forms as treatment progresses and new behavioral needs are identified; Site Coordinator and Executive Director will be responsible for ensuring all direct care employees read, comprehend, and acknowledge receipt of the training form on the first shift worked after client admission. Client Specific Training Forms were edited as part of the POP. Forms are completed at time of admission based on prescreen information and admission information from psychiatric evaluation, nutritional assessment, history and physical, and biopsychosocial assessment. Forms are updated as needed as treatment progresses and signed within 24 hours of completion or at the start of next shift worked.	

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 108	Continued From page 5 activities. -She had signed a confidentiality waiver but received no client specific information. She did not know client histories or goals of treatment. -"There was always a facility staff there with us." Interview on 3/15/21 with the Coordinator for local healthcare personnel agency #1 revealed: -They completed background checks, HCPR (Health Care Personnel Registry) and fingerprints if not in NC (North Carolina) for 5 years. -Temporary staff started 2/19/21. -Tapestry provided NCI (North Carolina Interventions) training. -They do not provide staff with additional training in MH/SA but their staff would be trained in dementia, weight bearing and lifting and dieting. Interview on 3/11/21 with the Director of local healthcare personnel agency #2 revealed: -They provided the training such as orientation, OSHA (Occupational Safety and Health Administration) and HIPAA (Health Insurance Portability and Accountability Act) requirements. -They completed criminal background checks, Office of Inspector General and HCPR. -Their corporate HR (human resources) completed the background checks. -CNA's (certified nursing assistants) nursing board reviews their background. -PCA-(personal care assistants) provide personal care for those who are independent with ADLs (activities of daily living). -"We just got the de-escalation training- NCI+." -Were told when contracted staff were on duty, they would never be alone. -They would also be "given a sheet about the clients." Interview on 3/18/21 with the Executive Director	V 108		

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V 108	Continued From page 6 revealed: -The Site Coordinator (SC) was responsible for client specific training for staff. The SC went over this client specific information with staff then staff signed the document to indicate they had received training. -She did not know why all staff had not received these trainings. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10 A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 7 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. This Rule is not met as evidenced by: Based on record review, and interview the facility failed to ensure that 2 of 2 audited Qualified Professionals (Site Coordinator, Executive Director) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 3/4/21 of the Site Coordinator (SC)'s job description revealed: -"Oversee, manage and direct the daily operations of the Tapestry Site..." -"Synchronizes all scheduling for external and internal customers for both clinical and non-clinical functions of the program and ensures proper personnel are included ..." -"Coordinates with Regional Human Resource [HR] Director: -Assures all HR and credentialing paperwork is processed for all employees, interns and contract workers; -Coordinates the onboarding process for new hires, interns and contractors;	V 109	**POC:** Site Coordinator & Executive Director will meet every Monday to review weekly BHT schedule. Site Coordinator, Executive Director, and VP of Operations will consult weekly and at time of shift change regarding alternative plan should a BHT "call out." If there are no additional alternatives identified, Site Coordinator or Executive Director will plan to cover shifts. Site Coordinator, Executive Director and Executive VP of Operations will review all scheduled staff members, call outs, and plans for re-staffing for compliance at each shift change. Site Coordinator reviews shift checklists daily to ensure compliance to protocols for client supervision. Executive Director reviews shift checklists weekly and reviews needs identified in weekly BHT meeting and during individual supervision. Site Coordinator pulls reports for weekly FOB checks at the end of each week. Executive Director reviews FOB check and addresses any deficiencies with Site Coordinator and/or BHT during individual supervision and BHT team meeting.	

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V 109	Continued From page 8 -Ensures that staff have completed required initial and annual required trainings." -"Provide or coordinate client supervision." -Supervised by the Executive Director (ED). Review on 3/19/21 of job description for the ED revealed: -"Carries out the personnel management activities associated with direct staff supervision , including...orientation training and development..." -"Directs all Tapestry operations ...Oversees and manages staffing patterns for Tapestry programming ..." -" ...Manages staffing patterns to ensure clients are effectively being served ..." -"Provide weekly direct supervision for ...SC of [Tapestry Adolescent Program] Fletcher." Interviews on 2/19/21 and 2/26/21 with Client #2 revealed: -There since 1/28/21. -"I'm playful and respectful of staff so staff treat me well." -"Staff aren't trained well. They don't know how to talk to eating disorder kids." - "Temp [temporary] staff asked what our favorite food was." She told the Site Coordinator (SC) and was told if temp staff says things again to report it. -Another staff was food bashing. -SC slams doors and is always on her phone. She had kids sit in hallway to write complaints. Just is not professional. -2 days ago around dinner time, SC got upset. "I didn't feel safe." -Didn't feel unsafe with boys at facility. -"All of us hung out together. Boys are always around to do anything with. I could have had sex if I wanted."	V 109		

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V 109	Continued From page 9 -One staff would fall asleep. They weren't doing 15min checks before. -"Staff were always asleep or on their phone." -"I'm supposed to count when I go to the bathroom. Staff never stood outside door." -"Depends on who is working. Sometimes have to count or crack the door." -"A lot of new staff don't know what to do." Client #1 has flashbacks. It happens in the moment where she is and staff will tell her to say 5 things she could see (not what is supposed to happen). One of the kids helped her with it, coming back to where she is. Interviews on 2/17/21 and 3/4/21 with Client #3 revealed: -2 or 3 staff are good. One staff threatened to beat a client's a*s. Staff dropped client's pills and just threw them away. Clients were grabbing the pills to take -FC #4 had a butter knife hidden in her room. She was cutting her arms. -1 staff worked overnight -"[Client #2] and [non-audited FC #7] were sitting on the same couch in the group room upstairs and had a blanket over them doing stuff." -No blankets are allowed in the group room any more, but can have them sometimes. -"[The Site Coordinator (SC)] scares me. Other staff was threatened. I don't feel safe." -"Had a big blow out with [SC] last night. She was slamming doors. We had timeout in the hallway. She was telling us her opinion about food." -"Staff food bashed making us feel bad. Staff called it (the food rules) 'retarded'." -Staff were supposed to complete checks overnight. -"[Client #2] said [FS#4] was sleeping in the group room." -"Staff showed pics of previous clients in a group	V 109		

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V 109	Continued From page 10 selfie." -Kids would sneak phones in. -"It doesn't feel really safe." -Not supposed to be in someone else's bedroom. Would always go into each others room. -2 girls now love each other. "They told me about sneaking into each others room. They said staff just touch the button and leave." -There's supposed to be someone (staff) in the middle of the hall but there hasn't been. They go downstairs. -She got up to go to the bathroom overnight and didn't see staff anywhere. -(Client #1)'s room is next to group room. She has nightmares and can't find staff. -No access to cell phones any more. -Clients were supposed to do school work on computers in art room but were still able to get on social media on computer. -"Saw [Client #2] and [non-audited FC #10] with medications- [non-audited FC #7 and non-audited FC #8] had vape." -Staff did room searches but didn't look good enough. Interview on 2/19/21 with the SC revealed: -Worked at sister facility since July 2019. -Transferred to Tapestry adolescent facility 1/4/21. -Duties included hiring and supervising BHTs (Behavior Health Technicians), utilization, contacting insurance companies, operations, maintenance- sort of the 'house mom'. -Screened applications then send to ED and HR. -Was in charge of trainings, "have lead techs train onboarding policies-standard required trainings." -Lead techs were expected to role model procedures with kids. -New staff do 40 hours of shadowing before they're left alone.	V 109		

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V 109	Continued From page 11 -At least 2 staff worked each shift dependant on number of kids. 2 staff work on evenings. -Still hiring staff but shifts were covered. -"The night of the [client sex] incident [on 1/30/21] had 2 staff. [Former Staff (FS) #4] had worked 3-11 and was asleep; the other staff couldn't get in due to the weather." -"Taking inventory of what was happening." Trying to determine where there were gaps and needs for improvement. -Around January 20-22 when system was updated and given to SC, the fob system reports showed specific time and location to verify room checks. -Re-implemented fob touch (15 min checks)-reviews report every morning. -Can view cameras on phone from home -Now kids follow a strict schedule. Divided kids into 2 groups. At 4-5:30-1 group upstairs in showers/phone calls while the other group is downstairs doing homework. After dinner at 5:30 the groups swap, 6:15-7:45. At 7:45-8:30 all together in group room watching movies, playing cards/games. Snack and medications at 8:30 and back to group room until 9:30 when they go to their rooms. Lights out at 10pm. -Expects staff to monitor kids in group room together. Kids are fully clothed, no blankets, not sitting together. -Expectations of 3rd shift were that each tech had specific duties. One tech was the hall walker who was responsible for touching fobs and looking for kids in their beds. The other tech preps meals, did cleaning, laundry. Staff were hand writing room check reports. -FS #4 was the only staff working the night of the client sex incident (see V179 regarding incident on 1/30/21). FS #4 was hired before SC got there. She tried to re-train FS #4 in basic shift requirements. The fob system was not in place	V 109		

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TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

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V 109	Continued From page 12 when FS #4 worked there. Interviews on 2/17/21 and 2/26/21 with the ED revealed: -Started new position 1/4/21 as ED. She was previously Clinical Director 2.5 years -"We had a really bad 8 weeks. There was a lack of checks and balances. We got some good things in place beginning in January; -Retrained staff to be alert-pay attention to what's going on around you -Moved [SC] from our Brevard location in January to provide on site supervision at our Fletcher location. She stays on top of staff supervision and is here to shadow staff 'all the time'. Also provides staff training. -Created BHT (behavioral health technician) checklist and added 40 hours of shadowing for each new staff. -Moved fob buttons inside bedrooms from outside each door and required 15 min checks." -"I learned the reports were not pulling up around the middle of the month of January and contacted maintenance. You should be able to pull a report that documents when the fob touched the display indicator on each bedroom." -The cameras have been installed since day 1 of facility opening. 2 cameras, kept glitching (going out) due to poor internet connection. IT (Information Technology) and maintenance both came to exchange ethernet cords and repair cameras. -ED and SC monitored cameras from their computer/phone and documented video log checks. -She was not aware all temporary staff had not received client specific training. Interview on 2/26/21 with the Vice President of Clinical and Quality Management revealed:	V 109		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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

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V 109	Continued From page 13 -In September 2020, the program director had medical issues and had to work remotely. Things progressively went downhill. "We were noticing things falling in the cracks, just not up to our standard. We began to retrain and rehire. Covid made staffing very challenging. The need for our services increased during Covid and we felt that we needed to increase census to cover the need. We contracted with temporary personnel agencies to help cover overnight shifts. We have 2 staff overnight dependent on census usually 7-8 kids. Males/females have always been on opposite ends of hall. On 2/15/21 we flipped all beds to female and put admissions on hold 2/19/21. We have been within ratio since 2/11/21." Interview on 3/18/21 with the Vice President of Operations revealed: -"HR was not responding quickly enough and we needed qualified staff quickly." -"I thought temps were a package deal -ready to go- trained in client care-only needed to do client specific training." This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 109	The lack of competency was, in part, based on client interviews, which is a concern based on the way the investigation progressed.The multiple, repetitive interviews during the course of the investigation and the use of showing client specific videos to illustrate the questions had a significant impact on the investigation and subsequent client narrative. A clarification to the survey notes should be noted. Our census/ capacity has always stayed the same throughout the pandemic. The discussion on increased census was related to the increased mental health need during COVID experienced in the community. Tapestry Fletcher has been in ratio since 2/11/2021 – prior to auditor entering facility. **POC:** Site Coordinator & Executive Director will meet every Monday to review weekly BHT schedule. Site Coordinator, Executive Director, and VP of Operations will consult weekly and at time of shift change regarding alternative plan should a BHT "call out." If there are no additional alternatives identified, Site Coordinator or Executive Director will plan to cover shifts. Site Coordinator, Executive Director and Executive VP of Operations will review all scheduled staff members, call outs, and plans for re-staffing for compliance at each shift change.	
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	V 112	Site Coordinator reviews shift checklists daily to ensure compliance to protocols for client supervision. Executive Director reviews shift checklists weekly and reviews needs identified in weekly BHT meeting and during individual supervision. Site Coordinator pulls reports for weekly FOB checks at the end of each week. Executive Director reviews FOB check and addresses any deficiencies with Site Coordinator and/or BHT during individual supervision and BHT team meeting.	

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V 112	Continued From page 14 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 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 reviews and interviews, the facility failed to develop and implement treatment plans based on assessments for 1 of 3 audited former clients (FC #5). The findings are: Record review on 2/26/21 for FC #5 revealed: -date of admission-11/20/20 -date of discharge-2/1/21 -age-16 -diagnoses-Depression, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, history of polysubstance use/experimentation -history of hospitalization for self-harming; school suspensions for substance use; unmotivated, not	V 112	**POC:** All treatment plans will have treatment goals set that match client's current diagnosis upon admission and will have treatment plan updates that incorporate new clinical information learned throughout the course of treatment. Clinical Director will review treatment plan (PCP) each week during individual supervision with the treatment team.	

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TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

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V 112	Continued From page 15 doing well in school; sexually active past 6 months. According to facility's biopsychosocial assessment dated 10/22/20 client reported "he has been so depressed that it was interfering in his life. He feels like he is so depressed that he doesn't really care. Reports it has been going on for about a year, has caused him to smoke pot, is behind in school and isn't motivated to do anything but watch youtube. Says he feels empty. It started when he got caught smoking pot and had to go to another school which caused him to become depressed and get into trouble." -Facility's psychiatric evaluation dated 11/23/20 revealed FC #5 reported "he has always felt depressed, unmotivated, sad, don't care about anything or himself or others. History of passive SI [suicidal ideation] a few months ago. History of active SI plan to OD [overdose] 2 years ago but didn't do it. History of SH (self harm) but not recently ...Lives with siblings, dad, step-mom; smokes 2-5 cigs/day, binge drinks-once a month. History of THC (tetrahydrocannabinol) use, last use 2-4 months ago; used it almost daily in 9th grade. 'It doesn't help me.' Has tried molly about 16 times. Experimented a few times with illicit benzos, LSD (Lysergic acid diethylamide), illicit adderall ..." -psychiatric evaluation and management dated 1/28/21 revealed FC #5 "reports that last night he punched a door (hollow, 2 slabs of particle board) and hurt his right hand. He was feeling angry and punched it because he was accused of stealing. Reports increased anger or angry outbursts. States he feels he bottles stuff up and doesn't talk about it. Mood: 'anxious sometimes' interested in PRN for anxiety." - Review of a therapy note dated 1/27/21 revealed "[FC #5] appeared to have a lot more insight on his substance use and how he would like to prevent substance use from happening."	V 112		

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V 112	Continued From page 16 -Treatment Plan dated 10/22/20 addressed goals: -for depression-client will exhibit decrease symptoms of negative thinking and depressed mood through DBT (Dialectical behavior therapy) emotion regulation groups -by developing a list of their automatic thoughts- by identifying specific thoughts/feelings/behaviors- by making a list of what patient is depressed about in group, individual or family sessions- by developing a deeper awareness of his emotions during groups weekly. -will learn about depression, factors that influence its development and continuance and methods for overcoming it and preventing its relapse -by identifying specific thoughts/feelings/behaviors-developing a list of automatic thoughts-by participating in DBT emotion regulation groups- by making a list of what patient is depressed about in group, individual or family sessions- by developing a deeper awareness of his emotions during groups weekly. -there were no goals or interventions to address previous polysubstance use/experimentation nor to address illicit usage with co-occurring mental health issues as well as with psychotropic medications. Attempts to reach FC #5 on 3/5/21 were unsuccessful. Interview on 3/18/21 with the Vice President of Clinical and Quality Management revealed: -"We addressed their primary presenting problem of depression with appropriate interventions." -"I don't agree with your opinion-we are meeting the rule." Refer to V179 for additional information regarding FC #5.	V 112		

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V 112	Continued From page 17 This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 112	**POC:** All treatment plans will have treatment goals set that match client's current diagnosis upon admission and will have treatment plan updates that incorporate new clinical information learned throughout the course of treatment.	
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	Clinical Director will review treatment plan (PCP) each week during individual supervision with the treatment team.	

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V 118	Continued From page 18 This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to keep the MAR current, failed to follow the written order of a physician for 3 of 3 audited current clients (Client #1, #2 and #3) and 2 of 3 audited former clients (FC #4 and FC #5). The findings are: Record review on 3/2/21 for Client #1 revealed: -date of admission-10/8/20 -age-14 -diagnoses- Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Eating Disorder, Autism Spectrum Disorder (ASD) Physician ordered medication included: -Vitamin D3 2000iu (international unit) (vitamin deficiency)- take every morning- ordered on 1/14/21 -Prazosin 1mg (milligrams) (nightmares)- one at bedtime- ordered on 12/23/20 -Latuda 20mg-(depression)- one at bedtime-ordered on 2/4/21 decrease from 40mg -Latuda 40mg-(depression)- one at bedtime-ordered on 2/1/21 and 2/11/21 increase from 20mg -lamotrigine 25mg- (depression)- twice daily-ordered on 10/15/20 -lamotrigine 100mg- (depression)- twice daily-ordered on 10/15/20 -Fluoxetine 20mg (depression)- one at bedtime-ordered 10/15/20 -hydroxyzine 10mg (attention) twice daily -ordered 10/15/20 -trazadone 50mg (sleep)- one at bedtime -ordered 10/15/20	V 118	**POC**: MARs are audited daily, and weekly by Site Coordinator and Program Nurse, and Executive Director. Executive Director will review nursing checklist daily to review med errors and compliance to MAR protocol. First shift BHT will review medication at end of each shift and notify nurse if there are less than 3 meds in client's med box to ensure medication is always received. Program provider will write order for medication to begin when medication arrives from pharmacy to ensure reduction in medication errors. Executive Director will meet with nurse weekly to review compliance to medication policy.	

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V 118	Continued From page 19 Review on 2/26/21 of MARs from 1/1/21-3/14/21 for Client #1 revealed: -Vitamin D3 2000iu - no documentation of administration on 1/29/21. -Prazosin 1mg- no documentation of administration on 2/4/21, refused on 1/8/21, 3/3/21, 3/4/21 -Latuda 20mg- no documentation of administration on 2/11/21 -Latuda 40mg- no documentation of administration on 2/4/21; refused on 3/3/21 -lamotrigine 25mg- not available for administration/missed on 12/12/20; refused on 1/8/21 -lamotrigine 100mg- not available for administration/missed on 12/20/21; refused on 1/8/21 -Fluoxetine 20mg- not available for administration/missed on 12/12/20, 12/14/20, 12/16/20, 3/14/21; refused on 1/8/21 -hydroxyzine 10mg- refused on 1/8/21 -trazadone 50mg- refused on 1/8/21, 2/19/21 Record review on 2/18/21 for Client #2 revealed: -date of admission-1/28/21 -age-16 -diagnoses- depressive disorder, anxiety disorder, eating disorder-orthorexia. Physician ordered medication included: -Calcium 500 (supplement)- twice daily - ordered 1/28/21 -Multivitamin (supplement)- once daily-ordered 1/28/21 Review on 2/26/21 of MARs from 1/1/21-3/14/21 for Client #2 revealed: -Calcium 500 - no documentation of administration on 2/1/21 am dose and 2/4/21 pm dose.	V 118		

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V 118	Continued From page 20 -Multivitamin - no documentation of administration on 2/1/21 Record review on 3/3/21 for Client #3 revealed: -date of admission-1/25/21 -age-13 -diagnoses-major depressive disorder (MDD), anxiety disorder, Anorexia Nervosa, restricting type, hypothyroidism Physician ordered medication included: -Hydroxyzine 25mg (anxiety)- 1 tab three times a day-ordered on 1/26/21 -Miralax (constipation)-1 scoop with 8oz water daily-ordered on 1/26/21 Review on 2/26/21 of MARs from 1/1/21-3/10/21 for Client #3 revealed: -Hydroxyzine 25mg - no documentation of administration on 1/27/21 am and noon doses, 1/28/21 noon dose, 2/11/21 noon and pm doses -Miralax - no documentation of administration on 2/28/21 Record review on 2/18/21 for FC #4 revealed: -date of admission-1/18/21 -date of discharge-2/1/21 -age-14 -diagnoses-major depressive disorder (MDD), generalized anxiety disorder (GAD), attention deficit hyperactivity disorder (ADHD) and anorexia. Review of physician orders failed to include an order for Vistaril. Review on 3/11/21 of MARs from 1/19/21-2/1/21 for FC #4 revealed: -Vistaril 10mg (anxiety) 3 times a day as needed as recorded on bottle- received 1 dose on 1/19/21, 1/21/21, 1/27/21, 1/30/21 and 2 doses on 1/29/21 and 1/31/21 without a doctor's order.	V 118		

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V 118	Continued From page 21 Record review on 2/26/21 for FC #5 revealed: -date of admission-11/20/20 -date of discharge-2/1/21 -age-16 -diagnoses-Depression, bipolar disorder, ADHD, history of polysubstance use/experimentation Physician ordered medication included: Concerta ER (extended release) 54mg (ADHD) once in AM- ordered on 11/23/20 Lamotrigine 100mg (bipolar) ½ tab at bedtime-ordered on 12/11/20 and discontinued 12/26/20 Abilify 2.5mg (depression) 1-tab x 3 days then discontinue - ordered on 1/7/21 Abilify 5mg (depression) once daily when 2.5 complete-ordered on 1/7/21 Review on 3/10/21 of MARs from 1/1/21-2/1/21 for FC #5 revealed: Concerta ER (extended release) 54mg - no documentation of administration on 12/26/20, 1/29/21 Lamotrigine 100mg - no documentation of administration on 12/15/20-12/22/20; documentation of administration on 1/8/21 after discontinue order. Abilify 2.5mg - no documentation of administration on 1/10/21 Interviews on 2/19/21 and 2/26/21 with Client #1 revealed: -Gets her medications on time. -Takes Prazosin, Trazadone, Latuda, can't remember all. 4 medications in the morning and a lot at night. -Takes all medications at once. "Staff check your mouth after taking medications but sometimes they forget." -"Staff may forget a medication but then call me up later."	V 118		

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V 118	Continued From page 22 -Some staff were medication trained. They had to watch other staff administer 1st before they did it independently. -Staff call clients 1 by 1 into medication room or if short staffed will have everyone stay in blue room. Interviews on 2/19/21 and 2/26/21 with Client #2 revealed: -Sometimes she notices 1 tablet missing from the medication cup and she brings it to staff's attention. -A few staff are medication trained. -In mornings, 1 at a time called to medication room for vitals, medications. At night all clients are in the blue room waiting. -Kids cheeked medications. Staff didn't pay attention. -Staff do medication counts. -"staff just aren't competent." -"[Staff #1] doesn't catch a lot." -New staff coming on are pretty good. Hiring better. Training is definitely different. -"I've seen changes. I was here when all that bad stuff was happening (short staffed, FC #5 had sex with FC #4, cheeking meds and snorting). Now staff are more strict and kids are complaining." Interview on 3/4/21 with Client #3 revealed: -When staff pass medications they call in one at a time. Sometimes they let other kids come into room. -She had 1 pill drop on the floor and staff made her take that one. -Now staff check our mouths. -Kids used to cheek medications then would crush and snort. Interview on 2/26/21 with the Nurse revealed:	V 118		

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V 118	Continued From page 23 -Completed an audit on 1/4/21 of MARs and found many MAR errors. Began retraining staff-Medication administration on 1/8/21, 1/22/21 and 2/22/21; Cheeking medications on 2/15/21; Understanding the MAR on 2/16/21; Medications missing on 2/16/21. Nurse from sister facility completed another audit on 2/16/21. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 118	**POC:** MARs are audited daily, and weekly by Site Coordinator and Program Nurse, and Executive Director. Executive Director will review nursing checklist daily to review med errors and compliance to MAR protocol. First shift BHT will review medication at end of each shift and notify nurse if there are less than 3 meds in client's med box to ensure medication is always received. Program provider will write order for medication to begin when medication arrives from pharmacy to ensure reduction in medication errors. Executive Director will meet with nurse weekly to review compliance to medication policy.	
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any	V 120		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	Continued From page 24 subsequent amendments. This Rule is not met as evidenced by: Based on interviews the facility failed to store medications securely for 3 of 3 audited current clients (Client #1, #2, #3) and 3 of 3 audited former clients (FC #4, #5, #6). The findings are: Interviews on 2/19/21 and 2/26/21 with Client #1 revealed: -sometimes staff leave the medication door unlocked Interviews on 2/17/21 and 3/4/21 with Client #3 revealed: -kids used to cheek medications-would crush and snort -"Saw [Client #2] and [non-audited FC #10] with medications ..." -staff did room searches didn't look good enough Interview on 3/5/21 with FC #4's mom revealed: -FC #4 was at the program for 12 days. -"Bys were there for substance abuse issues." -FC #4 told her that on group outings the boys sat in the back of the van and took Advil and Tylenol from the first aid kit. They would take it back to the facility, crush them and snort the powder. They also faked taking their medications so they could crush and snort those. Review on 2/23/21 of local social services worker's interview notes with FC #5 revealed: " ...[FC #5] stated that there was often only one staff member there even in the day. [FC #5] stated that staff would go downstairs and he said	V 120	**POC**: MARs are audited daily, and weekly by Site Coordinator and Program Nurse, and Executive Director. Executive Director will review nursing checklist daily to review med errors and compliance to MAR protocol. First shift BHT will review medication at end of each shift and notify nurse if there are less than 3 meds in client's med box to ensure medication is always received. Program provider will write order for medication to begin when medication arrives from pharmacy to ensure reduction in medication errors. Executive Director will meet with nurse weekly to review compliance to medication policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 120	Continued From page 25 that the residents would hang out. [FC #5] stated that they were not monitored at all. [FC #5] denies doing the white powder. [FC #5] stated that he knew other kids did it. [Social Services worker] asked where staff were and he stated down stairs. [Social Services worker] asked about kids being able to get into the medication area. [FC #5] said at first he did not think he could get into the medications. [FC #5] stated that the back door where the medications were kept was unlocked. [FC #5] then said, 'you probably could (get into the medication room). I never thought about doing it. 'I am not into meds.' [FC #5] did state that he heard other people doing it ..." Interviews on 2/25/21 and 3/10/21 with sister of FC #6 revealed: - FC #6 told her that kids stole medications, stole phones, boy/girls were touching/dating inside the facility, sent videos to groups on snapchat. -Kids stole medications from bag in van. Interviews on 3/4/21 and 3/17/21 with the Executive Director revealed: -"The first aid kit was kept in trunk of the van." -The kit itself was not locked nor was a compartment in the back of the van. -"Yes medication room downstairs had 2 doors but stayed locked." -The medication room had been moved to a room upstairs with one door and medications stored in a locked cabinet within that room. The room was moved on 1/19/21 to eliminate having to bring kids up and downstairs as it was too cumbersome for staff. -She was not aware of clients snorting white powder until she saw the video of and identified FC #5 snorting the white substance when local social services worker showed her on 2/12/21.	V 120		

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V 120	Continued From page 26 This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 120	**POC**: MARs are audited daily, and weekly by Site Coordinator and Program Nurse, and Executive Director. Executive Director will review nursing checklist daily to review med errors and compliance to MAR protocol.	
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 interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 3 audited clients (Client #1, #2) and 1 of 3 former audited clients (FC #5). The findings are: Review on 3/4/21 and 3/17/21 of medication incident reports from 12/1/20-3/14/21 revealed: -the following missed medications were discovered during 1/4/21 audit by nurse. There was no documentation of when the doctor or pharmacist was notified. -FC #5 -12/15/20-12/22/20 missed Lamictal -FC #5 -12/11/20-12/17/20 missed Abilify	V 123	First shift BHT will review medication at end of each shift and notify nurse if there are less than 3 meds in client's med box to ensure medication is always received. Program provider will write order for medication to begin when medication arrives from pharmacy to ensure reduction in medication errors. Executive Director will meet with nurse weekly to review compliance to medication policy.	

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V 123	Continued From page 27 -FC #5 -12/26/20 missed dose of concerta -Client #1- 12/12/20 missed Lamotrigine -Client #1- 12/12/20, 12/14/20, 12/16/20 missed Fluoxetine -the following refused medications were documented although it was unknown when the doctor or pharmacist was notified. -Client #1- 1/8/21 refused fluoxetine, Prazosin, Hydroxyzine, Latuda, Trazadone, Lamotrigine 25mg and 100mg -Client #1- 2/19/21 trazadone refused-physician notified 2 days later -Client #1- 3/3/21 refused Latuda, Prazosin-physician notified 3/2/21 a day prior to incident -Client #1- 3/4/21 refused Prazosin -the following unavailable medications were documented although it was unknown when the doctor or pharmacist was notified. -Client #2- 2/1/21-multivitamin and calcium not available- nurse notified -Client #1- 3/14/21 prozac- not delivered-received delivery at 4pm-no information to pharmacy or physician about earlier missing dose -In addition, 13 double doses of miralax and ensure, 22 refusals of docusate, trazadone, Miralax, Colace, fluticasone and 20 missed doses of abilify, Iron, Multivitamin, saline nasal mist, theram, Atarax, Colace, miralax, Pristiq, gabapentin, buspar occurred without immediate notification to a physician or pharmacist for 15 non-audited clients who were residents between 12/1/20-3/14/21. Interview on 2/26/21 with the RN (Registered Nurse) revealed: -When a client refuses a medication staff will text the RN and complete the Medication refusal form. The RN then contacts the PA (physician's assistant)-usually the following day. -There was no documentation when and if the	V 123		

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V 123	Continued From page 28 nurse contacted the PA. -The PA was there on Thursdays. The RN was able to change the MAR (medication administration record) with the order changes. -There were delays with medications coming in from the pharmacy. They were considering other pharmacy options with plans to switch pharmacies. -Completed an audit on 1/4/21 of MARs and found many MAR errors. Completed medication error/refusal reports. Began retraining staff-Medication administration on 1/8/21, 1/22/21 and 2/22/21, Cheeking medications on 2/15/21; Understanding the MAR on 2/16/21; Medications Missing on 2/16/21. Nurse from sister facility completed another audit on 2/16/21. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 123	**POC:** MARs are audited daily, and weekly by Site Coordinator and Program Nurse, and Executive Director. Executive Director will review nursing checklist daily to review med errors and compliance to MAR protocol. First shift BHT will review medication at end of each shift and notify nurse if there are less than 3 meds in client's med box to ensure medication is always received. Program provider will write order for medication to begin when medication arrives from pharmacy to ensure reduction in medication errors. Executive Director will meet with nurse weekly to review compliance to medication policy. The Program Nurse will notify Program Provider and Site Coordinator, in real time, and document on med incident report. Executive Director will review these med incident reports weekly during RN supervision.	
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by:	V 131	POC: HR is building a smartsheet to upload all new hire information for the facility to check prior to starting a new hire on shift. Executive Director and Executive VP of Operations will maintain personnel files for all site employees including all contract employees. Executive Director will be responsible for ensuring all contract agency employees have had all necessary trainings prior to starting at facility. Executive Director and Director of Performance Improvement will conduct monthly training audits to ensure compliance to the rule. Executive Clinical and Compliance Leadership (Executive Director, Director of Performance Improvement, and VP of Clinical Services and QM will conduct monthly audits and review to ensure compliance to the rules.	

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V 131	Continued From page 29 Based on record review and interviews, the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 2 of 3 audited current staff (Staff #2 and Staff #3) and 1 of 1 audited Former Staff (FS #4). The findings are: Record review on 3/15/21 for Staff #2 revealed: -date of hire- 2/22/21 -HCPR completed 3/15/21. Record review on 3/15/21 for Staff #3 revealed: -date of hire- 2/15/21 -no HCPR was presented when requested. Record review on 3/17/21 for FS #4 revealed: -date of hire- 12/7/20 -date of separation-2/4/21 -HCPR completed 2/22/21. Interview on 3/4/21 with the Executive Director revealed: -"We had a really bad 8 weeks. We got good things in place beginning in January." -"There was a lack of checks and balances even within HR(human resources). 3 people took over 1 job the previous director had." -HR was responsible for completing background checks. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN	V 133		

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V 133	Continued From page 30 APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 ofthis Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services,	V 133		

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V 133	Continued From page 31 Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider . All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction.	V 133		

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V 133	Continued From page 32 (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These	V 133		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 133	Continued From page 33 crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a	V 133		

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 133	Continued From page 34 criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to request a criminal background check within five days of a conditional offer of employment for 1 of 4 audited staff (Staff #2). The findings are: Record review on 3/15/21 for Staff #2 revealed: -date of hire- 2/22/21 -high school verification/graduation- Tampa, Florida May 2017. -criminal background check completed 2/17/21 did not include SBI (State Bureau of Investigation). Interview on 3/4/21 with the Executive Director	V 133	POC: HR is building a smartsheet to upload all new hire information for the facility to check prior to starting a new hire on shift. Executive Director and Executive VP of Operations will maintain personnel files for all site employees including all contract employees. Executive Director will be responsible for ensuring all contract agency employees have had all necessary trainings prior to starting at facility. Executive Director and Director of Performance Improvement will conduct monthly training audits to ensure compliance to the rule. Executive Clinical and Compliance Leadership (Executive Director, Director of Performance Improvement, and VP of Clinical Services and QM will conduct monthly audits and review to ensure compliance to the rules.	

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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

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V 133	Continued From page 35 revealed: -There had been a lot of changes in their corporate Human Resources department (HR). -HR was responsible for completing background checks. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 133		
V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall	V 179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

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V 179	Continued From page 36 coordinate with other individuals and agencies within the client's system of care. This Rule is not met as evidenced by: Based on record reviews, interviews and observations the facility failed to operate within the scope of their program which is to provide a structured living environment within a system of care approach for adolescents who have diagnoses of mental illness, emotional disturbance or other disabilities, affecting 3 of 3 audited current clients (Client #1, #2, #3) and 3 of 3 audited former clients (FC #4, #5, #6). The findings are: Cross reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V107) Based on record review and interviews the facility failed to ensure that a file was maintained for each individual employee for 10 of 10 Contracted Personnel (CP #5, #6, #7, #8, #9, #10, #11, #12, #13, #14). Cross reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) Based on record review and interviews the facility failed to ensure that each staff were provided training on the mental health/substance abuse (MH/SA) needs as specified in the treatment habilitation plan for 8 of 10 Contracted Personnel (CP #5, #6, #8, #9, #10, #11, #13, #14). Cross Reference: 10A NCAC 27G .0203	V 179	POC: There has been an increase in oversight and attention to detail of personnel files, medication management, staff training/supervision and increased focus of treatment plans. Executive Director and Executive VP of Operations will maintain personnel files for all site employees including all contract employees. Executive Director will be responsible for overseeing all contract agency employees have had all necessary trainings prior to starting at facility. POC: HR is building a smartsheet to upload all new hire information for the facility to check prior to starting a new hire on shift. Executive Director and Executive VP of Operations will maintain personnel files for all site employees including all contract employees. Executive Director will be responsible for ensuring all contract agency employees have had all necessary trainings prior to starting at facility. Executive Director and Director of Performance Improvement will conduct monthly training audits to ensure compliance to the rule. Executive Clinical and Compliance Leadership (Executive Director, Director of Performance Improvement, and VP of Clinical Services and QM will conduct monthly audits and review to ensure compliance to the rules.	

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 179	Continued From page 37 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review, and interview the facility failed to ensure that 2 of 2 audited Qualified Professionals (Site Coordinator, Executive Director) 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 reviews and interviews, the facility failed to develop and implement treatment plans based on assessments for 1 of 3 audited former clients (FC #5). Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) Based on observation, record review and interviews, the facility failed to keep the MAR current, failed to follow the written order of a physician for 3 of 3 audited current clients (Client #1, #2 and #3) and 2 of 3 audited former clients (FC #4 and FC #5). Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V120) Based on interviews the facility failed to store medications securely for 3 of 3 audited current clients (Client #1, #2, #3) and 3 of 3 audited former clients (FC #4, #5, #6). Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V123) Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 3 audited clients (Client #1, #2) and 1 of 3 former audited clients (FC #5).	V 179		

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V 179	Continued From page 38 Cross reference: G.S. 131 E-256 HCPR PRIOR EMPLOYMENT VERIFICATION (V131) Based on record review and interviews, the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 2 of 3 audited current staff (Staff #2 and Staff #3) and 1 of 1 audited Former Staff (FS #4). Cross reference: G.S. 122C-80 CRIMINAL HISTORY RECORD CHECK (V133) Based on record review and interviews, the facility failed to request a criminal background check within five days of a conditional offer of employment for 1 of 3 audited staff (Staff #2). Cross reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVE TO RESTRICTIVE INTERVENTIONS (V536) Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention prior to providing services for 10 of 10 Contracted Personnel (CP #5, #6, #7, #8, #9, #10, #11, #12, #13, #14). Cross reference: 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (V736) Based on observation and interviews the facility failed to be maintained in a safe, clean, attractive and orderly manner. Review on 2/18/21 of Facility Incident Report regarding incident on 1/31/21 revealed: "At approximately 12:45 am [FC #5] asked [FS #4] to take shower due to 'product being in his hair that was bothering him'. [FC #5] informed [FS #4] that his toiletries were in the bathroom at the	V 179		

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V 179	Continued From page 39 far end of the hall. Client started shower at 12:45, [FS #4] checked on client by walking to bathroom and listening for water running at 1:00am; client returned to bedroom at 1:05am. The following morning, [FC #4], reported [FC #5] entered her room, woke her up, and [FC #4] and [FC #5] started cuddling. [FC #4] reports sexual intercourse was attempted and when she said she was uncomfortable it stopped. Staff at facility were notified of this incident on 1/31/21 at 10:30am. [Executive Director (ED)] and [Executive Vice President (VP) of Operations] were notified shortly after. On-site staff, got written statements from both male and female client between 10:30-11:00am. [FC #4]'s parents were notified at 11:15am. Parents asked to speak to daughter with on-site therapist. Session was scheduled for 12:30pm. Parents also asked be contacted by MD [Medical Director] to discuss 'morning-after pill'. [MD], called and spoke with parents and morning after pill was given at 1:31pm. After call with [FC #4] at 12:30, parents asked that client's primary therapist be notified and speak with client. Client's primary therapist was notified at approximately 12:20pm and spoke to [FC #4] shortly after. [FC #4]'s parents asked that [FC #4] be taken to the hospital for an evaluation and at approximately 1:45pm [Site Coordinator (SC)] took [FC #4] to [local Hospital] in which they reported they do not treat 'pediatric clients' and directed [SC] and [FC #4] to [another local Hospital]. ED, Director of Performance Improvement and Executive VP of Operations will meet on 2/1/21 to debrief on incident and evaluate the incident and move forward with appropriate steps. Internal chart audit was completed and clinical documentation met standard, shift domains will be discussed in weekly supervision with each BHT (behavioral health technician) and	V 179		

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V 179	Continued From page 40 documented by on site manager, request to move fobs inside of client's bedroom and make sure reports are pulling properly, ticket was submitted to discuss cameras and locations. Community meeting was held with clients to process any feelings that came from the incident." Signed by the ED on 2/1/21. Review on 2/25/21 of 2 undated photos and 2 undated videos received from a local school counselor that had been shared by FC #6's mom revealed: -photo #1- 3 young males standing together in what appears to be a bedroom in the facility. From left to right- 1 male was using both hands to display his middle fingers, 1 male in the middle held his finger over his upper lip and the 3rd male was making some type sign/symbol with his fingers with his right hand and held a cell phone in his left hand. - Client #2 identified the males from left to right as FC #5, non-audited FC #7 and non- audited FC #8. -photo #2- a young male and young girl appeared to be sitting on a couch. The young man was grinning with his mouth closed while the young girl was leaning over on the male's shoulder, her eyes squinting and hand covering her mouth as if covering her laughter. -Client#1 identified the female as FC #6 and the male as non-audited FC #9. -video #1- from a right side angle, 1 young male bent over what appears to be a bedside table on which was sitting a clear plastic cup containing 6-7 black ink pens/highlighter, playing cards, 5 lines of what appears to be white powder approximately the length of a playing card and 2 half lines of the same powder with powder like residue around the lines, an empty blue pen cartridge and a small pump bottle of a clear	V 179		

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V 179	Continued From page 41 substance. The male had a long narrow tubular item which resembled an empty pen cartridge in his hand which he put into the end of his nose and snorted one of the half lines of the white substance. Video lasted 3 seconds. -the ED identified the male as FC #5. -video #2- from the front right corner of a bedside table in front of a window, 4 crystal type gemstones, 5 lines of what appears to be white powder approximately the length of a playing card and 2 half lines of the same powder with powder like residue around the lines, a clear plastic cup containing 6-7 black ink pens, playing cards, 2 empty pen cartridges. The video continued from the table view up to view a young man drawing his hand up to cover his nose. Video lasted 3 seconds. -the ED identified the male as FC #5. Record review on 3/3/21 for Client #3 revealed: -date of admission-1/25/21 -age-13 -diagnoses-major depressive disorder (MDD), anxiety disorder, Anorexia Nervosa, restricting type and hypothyroidism Record review on 2/18/21 for FC #4 revealed: -date of admission-1/18/21 -date of discharge-2/1/21 -age-14 -diagnoses-major depressive disorder (MDD), generalized anxiety disorder (GAD), attention deficit hyperactivity disorder (ADHD) and anorexia. -history of 4 suicidal attempts, multiple hospitalizations, self harming behaviors including cutting, binging and purging Record review on 2/26/21 for FC #5 revealed: -date of admission-11/20/20	V 179		

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V 179	Continued From page 42 -date of discharge-2/1/21 -age-16 -diagnoses-Depression, bipolar disorder, ADHD, history of polysubstance use/experimentation -history of hospitalization for self-harming; school suspensions for substance use; unmotivated, not doing well in school; sexually active past 6 months. Record review on 3/3/21 for FC #6 revealed: -date of admission-10/22/20 -age-13 -diagnoses- Eating disorder unspecified, Major depressive disorder, Generalized Anxiety Disorder, Vitamin D deficiency. Review on 2/18/21 of FC #4's statement of the 1/31/21 incident revealed: "[FC #5] snuck in to my room at 1am and I was sleeping. [FC #5] got into the bed and we were cuddling, then he kissed me for like 5 minutes. He was feeling me up then he took his shirt off and he was fonding my chest. And he said 'have you anything with anyone before' and I said 'no'. We kissing more but he was doing it more than me. We moved around so that I could take off my pants. We dry humped and he reached under my underwear. He stuck one of his fingers in it and said, 'd**n you're so tight'. I was uncomfortable but I didn't know how to say no. Then I was on top and he was trying to stick his d**k in but it wouldn't fit. I kept trying to stop it by saying I think I hear something. It hurt so bad and I felt so deflied. We humped for like 10ish minutes with just the tip in and I kept saying ouch. I never said yes but I never said no." Review on 2/18/21 of Memo to Chart written by FC #4's therapist on 1/31/21 revealed: -"Clinician contacted parent and they were	V 179		

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V 179	Continued From page 43 concerned about the incidents that have happened last night. Clinician contacted patient to hear her perception of the night. Client began to say that a male peer had come into her room involuntarily. Clinician asked if anyone had known that he was going to come into the room and client stated that her roommate had known he was thinking about coming in but stated she felt as if her roommate was asleep because it was around 1:00am. Clinician asked if it was consensual and client reported that she cannot remember if it was and cannot remember if it had stopped because she said it hurt or if he was afraid of getting caught. Clinician had asked if client had felt safe in program and client reported yes that she had felt safe and that she was not worried being around peers. Clinician had asked client if there was anything that she needed from clinician and client stated to just manage her parents so that they do not take her out of program because she knows that going home would not be good for her. Clinician contacted parents and informed them of what client had stated and parent with clinician will be meeting with client in the morning to have family session." Review of FC #5's statement of 1/31/21 incident revealed: "Me and [FC #4] were in the upstairs group room and I said I don't want to cuddle around everyone and [FC #4] said you can just wake me up and I said ok. When we were getting ready for bed I told her I would try to wake [FC #4] up and she smiled and said ok. Then I went to bed and waited tell about 12:14 then I walked out to the Blue room and said I was going to take a shower at the end of the hall to [FS #4] and she said ok so I pretended to walk down the hall and woke [FC #4] up and she woke up and invited me into the bed by scooting over and picking up the	V 179		

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V 179	Continued From page 44 blanket so I could get under so I did we kissed a couple of time and cuddled and before we cuddled I asked if she wanted to and she said yeah then she took her pants off because I asked if she wanted 'to do it' and she said yeah and got on top of me and I asked again when she was on my lap if 'you want to have sex' and she said yeah while I was rubbing her vigina and she took her underwear off and I asked 'are you sure you want to do this' and [FC #4] said yeah so I tried putting my penis in [FC #4]'s vigina and went in and out then after she and were done have sex I pulled my pants up and shirt on at 1:05 and gave her a kiss and said 'goodnight' and [FC #4] said it back then I walked back to my room and said goodnight to [FS #4] that I told I was going to go take a shower. I walked to my room and went to bed when I woke up I told my friend but all I said was that 'me and [FC #4] f****d.'" Interviews on 2/17/21 and 3/4/21 with Client #3 revealed: -Shared room with FC #4. -2 or 3 staff are good. One staff threatened to beat a client's a*s. She dropped a client's pills and just threw them away. Clients were grabbing the pills to take. -FC #4 had a butter knife hidden in room and was cutting her arms. -1 staff worked overnight. -FC #4 asked her if she was ok with FC #5 coming in at night. "She told [FC #5] I wasn't comfortable with it. I hadn't said that so I felt [FC #4] was uncomfortable." -She asked FC #4 if FC #5 had come in and she said no. "Later in the morning [FC #4] was bragging about it. I forced him to do it and then became quiet. She said she wanted to talk to staff. [FC #4] reported he raped her. I didn't see her the rest of the day."	V 179		

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V 179	Continued From page 45 -FC #5 said he didn't do nothing. FC#4 was the instigator. -FC #5 was a leader. He was very kind. He had to leave that night. -"Didn't know [FC #4] had gone to the hospital. She came in next morning to pack her stuff. She wrote me a note 'I'm leaving- I was raped'." -"[Client #2] and [non-audited FC #7] were sitting on same couch in group room upstairs and had blanket over them doing stuff." -No blankets allowed in group room any more but can have them sometimes. -Saw Client #2 and non-audited FC #10 with medications. -Staff did room searches but didn't look good enough. Interview on 3/5/21 with FC #4's mom revealed: -FC #4 was at the program for 12 days. -"Boys were there for substance abuse issues." -FC #4 told her that on group outings the boys sat in the back of the van and took Advil and Tylenol from the first aid kit. They would take it back to the facility, crush them and snort the powder. They also faked taking their medications so they could crush and snort those. -FC #4 denied any use. -"Techs were let go while [FC #4] was there leaving all the clients vulnerable. The tech situation was not run correctly; if no one shows up, supervisors should show up." -FC #4 never had any sexual experiences before. -"There was a lot of he said she said but this boy [FC #5] who was 17 had woken [FC #4] from a sleep. She had taken melatonin." -The Site Coordinator (SC) kept saying FC #4 gave permission. "She's only 14 years old. I hold the Director and [SC] ultimately responsible. They treated [FC #4] poorly. Told [FC #4] she asked for it. The whole experience was awful.	V 179		

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V 179	Continued From page 46 Thankfully she's got a good therapist." Review on 2/23/21 of the interview by local social services worker with FC #5 revealed: " ...[FC #5] stated that they [group home staff in general] appeared unorganized like they were trying to figure things out. [FC #5] stated that there was often only one staff member there even in the day. [FC #5] stated that staff would go downstairs and he said that the residents would hang out. [FC #5] stated that they were not monitored at all. [FC #5] denies doing the white powder. [FC #5] stated that he knew other kids did it ... asked about kids being about to get into the medication area. [FC #5] said at first he did not think could get into the medications. [FC #5] stated that the back door where the medications were kept was unlocked. [FC #5] then said, 'you probably could, I never thought about doing it. I am not into meds.' [FC #5] did state that he heard other people doing it. [FC #5] stated that there were two boys to a room. [FC #5] stated he and another boy were in a room and then there were two other boys in another room. [FC #5] stated that one time they took in another boy and put a bed in the other room, putting three boys in the room and making it very cramped. [FC #5] stated that they seemed unorganized. [FC #5] stated that he felt like they were making up rules. [FC #5] stated that one day they allowed you to listen to your music and the next day you were not allowed. [FC #5] stated that staff would often go downstairs to clean and the residents were upstairs. [FC #5] stated that residents knew if you stayed up long enough that staff would go downstairs and then they could hang out. [FC #5] stated that they often went to the parking lot to play basketball and that staff would smoke out there as well and often would throw their cigarette butts on the ground where the residents could get	V 179		

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V 179	Continued From page 47 them. [FC #5] talked about the knife drawer in the kitchen. [FC #5] stated that staff would sometimes not lock it. [FC #5] stated that it was left open a lot and you could just reach in it and grab whatever you wanted. He said this happened all the time. He said that it was locked most of the time. He stated that if staff caught someone messing with it then they would lock it. [FC #5] stated that the drawer was right next to where they washed the dishes... [FC #5] stated that his parents would call and he would never be told. He stated that happened all the time. He stated that sometimes he was able to call and sometimes they would say it was after five and they were not able to call. [FC #5] again talked about the kids knowing that staff would go down of a night to the bottom floor and that they could hang out. [FC #5] did share that a time around before Christmas there were 12 residents and only 1 staff member working. [FC #5] talked about how staff allowed them when they were in the group room to run get stuff out of their rooms and take showers." Interview on 2/25/21 with FC #6's mom through an interpreter revealed: -She had had FC #6's phone since 2/11/21. -She only knows what she has seen on the phone. -FC #6 had confided in her older sister who suggested mom review phone. -FC #6 went to facility for anorexia. Her main concern was that no one would give her any information. FC #6 fell down the stairs and injured herself and staff refused to give her information-never made any effort to communicate with her. -FC #6 reported having nose bleeds. -Second admission was after new years. She called, whoever answered the phone didn't know	V 179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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 179	Continued From page 48 who FC #6 was which scared her so she and her 2 older children went immediately to the facility. Saw FC #6-noticed cuts on her arms-had scratched and cut before but these seemed deeper more noticeable. FC #6 seemed fearful. Both older siblings also felt uneasy about the place. "something was not right at that facility." Had a very difficult time discharging FC #6. The family was there from 2pm until 7pm. Other staff tried to talk her out of taking FC #6 home saying FC #6 would get into trouble. Therapist was concerned FC #6 would harm herself if she went home. Took FC #6 to the hospital and sent pictures back to staff showing she had taken FC #6 to hospital. FC #6 was angry at discharge. Mom told FC #6 staff reported she would hurt herself if she was discharged and FC #6 responded that she had not threatened that. -Her Primary Care Physician thought FC #6 could have been snorting the drugs too. Interviews on 2/25/21 and 3/10/21 with sister of FC #6 revealed: - FC #6 told her that kids stole medications, stole phones, boy/girls were touching/dating inside the facility, sent videos to groups on snapchat. -Kids stole medications from bag in van. -FC #6 sneaked a razor in a book. -Staff were very rude when the family showed up. -Date of videos and pictures sent in FC #6's cell phone were from 1/24/21 at 9:19pm. Interview on 2/19/21 with Staff #1 revealed: -Had worked for facility 3 years in May. -Usually worked 3rd shift 11p-7a. -Did meal prep; made breakfast, dinner for the next night. Did laundry. -Watched kids; during the week they go to bed 930-10; get up about 645. -Did weights and vitals.	V 179		

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V 179	Continued From page 49 -Only 1 staff on shift sometimes. "Since the beginning of Feburary I have been by myself about 5 times." -Wouldn't do meal prep if only 1 staff working. - Doing 15 mins checks with flashlight pointed at ceiling. Write sleeping on list. -"Had the fob system years ago. Don't know what happened to it but 2 weeks ago started using it again." -Sit in Blue Room to watch the boys and 2nd staff is in group room. Write notes in am. -Did 15 mins checks but wrote only 1 note. -Never had a problem with boys sneaking down to girls room. Review on 3/17/21 of 1st Plan of Protection dated 3/17/21 and signed by Vice President of Clinical Services and Quality Management revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Cross-referenced GS.131E-256 HCPR-Prior Employment Verification (v131) Cross-referenced GS 122C-80 Criminal History Record Check (v133) Cross-referenced 10A NCAC 27G .0202(a-e) Personnel Requirements (v107) POP: Personnel file issues with lack of file for temps, lack of NCI training, SBI criminal background check, and lack of HCPR. -HR/ Onboarding processes including mandatory trainings (i.e., NCI), background checks including criminal background check and HCPR, and creation and maintenance of personnel files for all employees working in the facility (temp, contract, PT, and FTE) will be monitored at the facility level by the Executive Director effective immediately. This process will replace the remote HR office responsibility with onsite, Executive Director oversight.	V 179		

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V 179	Continued From page 50 -Person Responsible/ Timeframe: Prior to any employee start date, Executive Director will ensure all requirements are met. Effective immediately 3/17/21. Cross-referenced 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (v109) POP: Concerns related to client supervision and staff training. -Previous Program Director was identified as unwilling to complete her job responsibilities and was terminated on 12/24/20 and replaced with new Executive Director. -Current Executive Director reviews all scheduled staff members, call outs, and plans for re-staffing for compliance at each shift change. Shift call was implemented on 2/15/21 and occurs three times daily. -Executive Director retrained and re-implemented daily shift checklists for all three shifts on 2/10/21. -Checklists are reviewed daily by Executive Director, weekly in tech meetings, and weekly in individual supervision. Executive Director implemented a video monitoring log on 2/10/21 for documenting video surveillance during night shift. -Executive Director placed fob system inside client rooms to ensure behavioral health tech staff adhere to routine visual checks for the duration of third shift. The fobs produce a report for each touch point that is monitored by the Executive Director effective 2/10/21. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of site coordinator, client supervision, and staff training; shift change review call implemented on 2/15/21, and video surveillance monitoring and fob monitoring implemented on 2/10/21.	V 179		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 179	Continued From page 51 Cross-referenced 10A NCAC 27G .0209(c) Medication Requirements (v118) POP: There were errors in the medication process. -Executive Director implemented checklist for RN to review in supervision, which includes medication incident review each day and BHT med pass sign off sheet on 2/22/2021 -Program Nurse conducts random med pass spot checks as of 3/1/2021, which is monitored by Executive Director. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of RN with support from Executive VP of Operations, Medical Director, Physician's Assistant, Divisional Nursing Team, and Corporate Director of Nursing. Cross-referenced 10A NCAC 27G .0209(e) Medication Requirements (v120) POP: Client report of access the medication in the first aid kit. -The first aid kit will be stored in a locked safe in the van as of 3/17/21. -Prior to the survey, the medication storage room moved from downstairs to upstairs in order to contain and limit access to medication room. -Person Responsible/ Timeframe Executive Director will check first aid kits on a weekly basis to ensure that contents of kit are not accessible to clients effectively immediately. Cross-referenced 10A NCAC 27G .0209(h) Medication Requirements (v123) POP: For a missed medication, there was not an immediate notification to pharmacy or PA of missed medication. -RN trained to contact PA and Executive Director at each missed medication and medical incident to ensure compliance to guidelines. -Executive Director implemented checklist for RN	V 179		

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V 179	Continued From page 52 to review in supervision, which includes medication incident review and medication refusal review each day. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of RN in collaboration with team listed above. Daily check in with RN implemented on 2/22/21 in addition to weekly supervision with Executive Director. Cross-referenced 10A NCAC 27G. 1302 Staff (v180) POP: There were instances of non-compliance with staff ratio. -Executive Director executed contract with temp agency on 2/12/21 to ensure staffing ratio compliance. In addition, Executive Director reviews all scheduled staff, call outs, and client specific needs with Site Coordinator at shift change each day to ensure that changes to schedule are appropriately addressed for client supervision and safety. Executive Director will ensure that all shifts are covered and staffing ratios are in compliance with standards and will not operate out of compliance. -Leadership team retrained Site Coordinator on weekly staffing report related to onboarding , resignations/ terminations, open positions, and hiring process on 2/15/21 and 3/1/21. -Person Responsible/ Timeframe: New Executive Director responsible for oversight of Site Coordinator, Staffing/ Schedule, and Shift Change Adjustments. Shift Change Staffing Call effective 2/15/21. Retrained Site Coordinator on weekly staffing report on 2/15/21 and 3/1/21 Cross-referenced 10A NCAC 27G . Physical Plant. 0303 (v736) POP: There were noticeable holes in the walls of the facility -The holes have been repaired as of 3/8/21.	V 179		

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V 179	Continued From page 53 -There have been additional facility repairs and upgrades including interior painting of all walls. -Executive Director scheduled consultation with Facilities Director weekly to complete walk through of facility to prevent future occurrences of disrepair beginning 2/15/21. -Oversight of Maintenance Department and Housekeeping moved to internal/ NC based leadership as of 3/5/21. -Site Coordinator retrained on weekly operational reporting related to maintenance, housekeeping needs for facility on 3/3/21 and 3/5/21. Physical plant issues tracked weekly on Fridays at 10:30am through weekly operational report. -Person Responsible/ Timeframe: New Executive Director is responsible for oversight of physical plant. Wall repair on 3/8/21; retraining of physical plant upkeep call on 2/26/21; weekly walk through with Executive Director and Facility Director beginning 2/15/21 and ongoing. Describe your plans to make sure the above happens. Executive Director and Executive Vice President of Operations, meet for supervision two times per week to review the protocols and plans stated above. Executive Director will conduct weekly group supervision with behavioral health tech staff and oversee weekly individual supervision with each behavioral health technician with review of compliance and safety focused checklist at each supervision (daily, weekly, and group). Executive Director will also provide daily shift supervision for Site Coordinator, weekly clinical supervision for primary therapists, and daily and weekly supervision for Program Nurse.	V 179		

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V 179	Continued From page 54 Executive Director, VP of Clinical Services and Quality Management, and Director of Performance Improvement and Training will meet monthly to review compliance to above stated protocols and plans in addition to daily supervision with operations team. In order to ensure focus on the corrections needed in response to survey feedback, Program leadership elected to stop admissions in order to provide appropriate care, retrain staff, reimplement essential processes, and stabilize areas of need. This was a productive change that has allowed stabilization and effective response . Admissions will remain on hold until Friday 3/19/21 during survey exit." Review on 3/22/21 of 2nd Plan of Protection dated 3/18/21 and signed by Executive Director, Executive Vice President of Operations and VP of Clinical Services and Quality Management revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Cross-referenced GS.131E-256 HCPR-Prior Employment Verification (v131) Cross-referenced GS 122C-80 Criminal History Record Check (v133) Cross-referenced 10A NCAC 27G .0202(f-i) Personnel Requirements (v108) Cross-referenced 10A NCAC 27G .0202(a-e) Personnel Requirements (v107) Cross-referenced 10A NCAC 27E .0107 Training on alternatives to restrictive interventions (v536) POP: Personnel file issues with lack of file for temps, lack of NCI training, SBI criminal background check, and lack of HCPR. -HR/ Onboarding processes including mandatory trainings (i.e., NCI), background checks including	V 179		

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V 179	Continued From page 55 criminal background check and HCPR, and creation and maintenance of personnel files for all employees working in the facility (temp, contract, PT, and FTE) will be monitored at the facility level by the Executive Director and VP of Operations effective immediately. This process will replace the current remote HR office responsibility with onsite leadership oversight. -Person Responsible/ Timeframe: Prior to any employee start date, Executive Director and Executive Vice President of Operations will ensure all requirements are met New Hire checklist. Effective immediately 3/17/21. Cross-referenced 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (v109) POP: Concerns related to client supervision and staff training. -Previous Program Director was identified and self reported as unwilling to complete her job responsibilities and was terminated on 12/24/20 and replaced with new Executive Director. -Current Executive Director and Executive Vice President of Operations will review all scheduled staff members, call outs, and plans for re-staffing for compliance at each shift change. Shift call was initiated on 2/15/21 and will be fully implemented including VP of Operations on 3/18/21. This communication occurs three times daily. -Executive Director retrained and re-implemented daily shift checklists for all three shifts on 2/22/21. Checklists are reviewed daily by Executive Director, weekly in tech meetings, and weekly in individual supervision. Since this initiation there has been another re-conceptualization of shift checklist and starting 3/15/2021 BHT signs daily shift checklist. -Executive Director initiated a video monitoring	V 179		

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V 179	Continued From page 56 log on 2/10/21 for documenting video surveillance during night shift. Fully implemented on 2/19/2021. -Executive Director placed fob system inside client rooms to ensure behavioral health tech staff adhere to routine visual checks for the duration of third shift. The fobs produce a report for each touch point that is monitored by the Executive Director; initiated 2/10/21 and fully implemented 2/26/21. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of site coordinator, client supervision, and staff training; shift change review call implemented on 2/15/21, and video surveillance monitoring and fob monitoring initiated on 2/10/21 and fully implemented on 2/26/21. Cross-referenced 10A NCAC 27G .0209(c) Medication Requirements (v118) POP: There were errors in the medication process. -Executive Director implemented checklist for RN to review in supervision, which includes medication incident review each day and BHT med pass sign off sheet on 2/22/2021. -Program Nurse conducts random med pass spot checks as of 3/1/2021, which is monitored by Executive Director. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of RN with support from Executive VP of Operations, Medical Director, Physician's Assistant, Divisional Nursing Team, and Corporate Director of Nursing. Cross-referenced 10A NCAC 27G .0209(e) Medication Requirements (v120) POP: Client report of accessing the medication in the first aid kit. -The first aid kit will be stored in a locked safe in	V 179		

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V 179	Continued From page 57 the van as of 3/17/21. -Prior to the survey, the medication storage room moved from downstairs to upstairs in order to contain and limit access to medication room. -Person Responsible/ Timeframe Executive Director will check first aid kits on a weekly basis to ensure that contents of kit are not accessible to clients effectively immediately. Cross-referenced 10A NCAC 27G .0209(h) Medication Requirements (v123) POP: For a missed medication, there was not an immediate notification to pharmacy or PA of missed medication. -RN trained to contact PA and Executive Director at each missed medication and medical incident to ensure compliance to guidelines. -Executive Director implemented checklist for RN to review in supervision, which includes medication incident review and medication refusal review each day. -Person Responsible/ Timeframe: Executive Director is responsible for oversight of RN in collaboration with team listed above. Daily check in with RN implemented on 2/22/21 in addition to weekly supervision with Executive Director. Cross-referenced 10A NCAC 27G . Physical Plant. 0303 (v736) POP: There were noticeable holes in the walls of the facility -The holes have been repaired as of 3/8/21. -There have been additional facility repairs and upgrades including interior painting of all walls. -Executive Director scheduled consultation with Facilities Director weekly to complete walk through of facility to prevent future occurrences of disrepair beginning 2/15/21. -Oversight of Maintenance Department and Housekeeping moved to internal/ NC based	V 179		

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V 179	Continued From page 58 leadership as of 3/5/21. -Site Coordinator retrained on weekly operational reporting related to maintenance, housekeeping needs for facility on 3/3/21 and 3/5/21. Physical plant issues tracked weekly on Fridays at 10:30am through weekly operational report. -Person Responsible/ Timeframe: New Executive Director is responsible for oversight of physical plant. Wall repair on 3/8/21; retraining of physical plant upkeep call on 2/26/21; weekly walk through with Executive Director and Facility Director beginning 2/15/21 and ongoing. Cross-referenced 10A NCAC 27G .0205(c) Assessment and Treatment/Habilitation or Service Plan (v112) The rule states the requirement of treatment plan development based on clients' presenting problem and clinical and psychiatric evaluation facilitated by the licensed, credentialed staff at the facility. Treatment plans were developed in accordance with the clients' presenting problem and are based on the diagnoses in the biopsychosocial assessment and the psychiatric evaluation. We feel this rule is met by our treatment plan. Tapestry's clinical orientation is an evidenced based, transdiagnostic approach that addresses core issues in a comprehensive way (Acceptance and Commitment Therapy). The clinical opinion of the surveyor was in opposition to the clinical judgment of the licensed clinician and medical provider. There were two clients in question related to this tag. Client One presented to treatment reporting pervasive depression, chronic feelings of emptiness, and several subsequent behavioral, social, and emotional issues as a result of the	V 179		

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V 179	Continued From page 59 depression. The client identified impulsivity, anger outbursts, experimental substance use, and interpersonal difficulties (among others) as secondary symptoms stemming from depression. A treatment plan was developed to address the primary, diagnosed concerns with goals to address secondary 'target behaviors' related to the depression. This is in accordance with the evidenced based modality used at Tapestry, which conceptualizes problematic behaviors (i.e., anger outbursts, substance use, isolation, etc.) as experiential avoidance. The treatment approach is aimed at addressing the depression and establishing value based behavioral change rather than solely addressing behavior modification (i.e., the symptom). The treatment plan does address target behaviors related to depression (which would include substance use among other behaviors). Therefore, we feel this rule is met. **This particularly client did address impulsivity, anger outbursts, substance use issues, and interpersonal/ familial issues during the course of treatment and in accordance with the treatment plan. Client Two has a long, pervasive history of complex trauma. It is not uncommon for clients with complex trauma to be misdiagnosed or, at the very least, to accumulate multiple diagnoses due to trauma symptoms masquerading as criteria for other diagnoses. The surveyor for this investigation is citing this deficiency (per surveyor verbal report) because Tapestry did not include a previous diagnosis (from a previous medical record obtained during the prescreening process) in the Tapestry treatment plan. The client's presenting concerns were related to trauma, eating disorder, and anxiety. Based on the clinical	V 179		

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V 179	Continued From page 60 presentation, reporting concerns, and recent and historical severe trauma, it is difficult to definitively determine the source of the client's physiological, emotional, cognitive, and social dysregulation apart from the understanding that the client's condition is trauma induced. The treatment plan was based on client's presenting concern, biopsychosocial assessment, and psychiatric evaluation. Therefore, we feel this rule is met. ***This particularly has had the opportunity to address complex trauma issues based on the program's clinical philosophy and continues to receive much needed biopsychosocial support from the Tapestry team as noted by the surveyor during the audit. The purpose of this explanation is in no way to be argumentative or difficult, but to explain the evidence based, clinical rationale for treatment planning. The question is not about the discussion, recommendations, or opinions of the surveyor or the state team. We respect and value the surveyor's feedback and have taken all of her recommendations and feedback seriously and as cause to initiate change. As stated in the interview on 3/18/21, the facility will incorporate the feedback into future practices. The issue is related to clinical nuance rather than compliance with the rule. POP, Person Responsible, and Timeframe: All behaviors will be assessed and acknowledged in client specific training and engagement for staff to ensure the team is identifying client specific needs for supervision. An additional section on the Client Specific Training Form will be added titled "Significant Client Behaviors and Plan" to ensure that client safety needs are addressed and all staff are notified. Executive Director responsible for oversight,	V 179		

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	MHL045-133	A. BUILDING: _____ B. WING _____	C 03/22/2021

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V 179	Continued From page 61 effective 3/19/21 Describe your plans to make sure the above happens. Executive Director and Executive Vice President of Operations, meet for supervision two times per week to review the protocols and plans stated above and conduct all new hire interviews together to ensure appropriate hiring and development of onboarding plan as of 2/26/21. Executive Director, Executive Vice President of Operation and Site Coordinator will consult at shift change 3 x daily to ensure staffing for shift is in compliance and any callouts/ staffing shortages are resolved. Executive Director will conduct weekly group supervision with behavioral health tech staff and oversee weekly individual supervision with each behavioral health technician with review of compliance and safety focused checklist at each supervision (daily, weekly, and group). Executive Director will also provide daily shift supervision for Site Coordinator, weekly clinical supervision for primary therapists, and daily and weekly supervision for Program Nurse. Executive Director, VP of Clinical Services and Quality Management, and Director of Performance Improvement and Training will meet monthly to review compliance to above stated protocols and plans in addition to daily supervision with operations team at 10:30am as of 3/1/21. In order to ensure focus on the corrections needed in response to survey feedback, Program leadership elected to stop admissions on 2/19/21 in order to provide appropriate care, retrain staff,	V 179		

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V 179	Continued From page 62 reimplement essential processes, and stabilize areas of need. This was a productive change that has allowed stabilization and effective response ." The facility admitted male and female adolescent clients with diagnoses of Bipolar Disorder, PTSD, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Autism Spectrum Disorder (ASD) in combination with Bulimia and Anorexia Nervosa. With full knowledge of his history of polysubstance use/experimentation no strategies were developed or implemented to address the treatment needs for FC #5. As appeared in shared social media content and shared text on 1/24/21, a 3-second video showed FC #5 snorting white powder in a facility bedroom. Alleged cheeking of prescribed medications and stealing medications from unsecured first aid kit were likely sources of the white powder. Interviews with other clients and family members as well as medical concerns of nose bleeds, support FC #5 was likely not the only client to snort crushed medications. On 1/30/21, FC #5 took advantage of the lack of adequate staff supervision during the overnight hours by sneaking into a 14 year old peer's bedroom to have sex. FC #4 had no previous sexual experiences and reported a painful episode. There was only 1 staff working that shift. The Licensee's VP of Operations signed contracts on 2/12/21 with local personnel agencies to fill staffing deficits but with untrained staff. The facility kept no personnel file, did not provide training in mental health, developmental disabilities or substance abuse to meet client specific needs nor were these contracted personnel trained in alternatives to restrictive interventions prior to working directly with clients. Additionally, 1 current staff had no SBI criminal background check and 2 current and 1 former	V 179		

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V 179	Continued From page 63 staff had no HCPR check prior to hire. While the Licensee's corporate HR was responsible for failure to complete background checks, staff training and scheduling was the Site Coordinator's responsibility. The Executive Director was ultimately responsible for the oversight of staff training and scheduling . The facility did not administer psychotropic medications that were critically important for the stability and safety of the clients as ordered. The MARs were not complete for 5 of 6 audited clients for Vitamin D, Prazosin, Latuda, Calcium, Multivitamin, hydroxyzine, Miralax, Concerta, lamotrigine and Abilify. Physician orders were not in place for administration of 8 doses of Vistaril for 1 client. Per medication error reports from 12/1/20-3/14/21, 13 double doses of miralax and ensure, 40 doses were missed, 33 doses were refused of Lamictal, Abilify, Concerta, lamotrigine, fluoxetine, Prazosin, hydroxyzine, Latuda, Trazadone, multivitamin, calcium, miralax, Colace, iron, saline nasal mist, Pristiq, gabapentin and buspar without immediate notification to a pharmacist or physician for 15 clients. Due to the failure to accurately document medication administration it could not be determined if clients received their anti-depressant, anti-anxiety, and anti-psychotic medications as ordered by the physician. These systemic failures resulted in serious neglect and constitute a Type A1 rule violation and must be corrected with 23 days. An administrative penalty in the amount of $3000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 179		

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V 536	Continued From page 64	V 536		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (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;	V 536		

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V 536	Continued From page 65 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (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	V 536		

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V 536	Continued From page 66 by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once 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.	V 536		

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V 536	Continued From page 67 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention prior to providing services for 10 of 10 Contracted Personnel (CP #5, #6, #7, #8, #9, #10, #11, #12, #13, #14). The findings are: Review on 3/3/21 of CP billing and 3/10/21 of NCI+ (North Carolina Interventions plus) training information revealed: -CP #1 first day of work at facility was 2/19/21 and trained on 3/3/21 -CP #2 first day of work at facility was 2/19/21 and trained on 3/3/21 -CP #3 first day of work at facility was 2/25/21 and trained on 3/2/21 -CP #4 first day of work at facility was 2/16/21- no NCI+ training certificate was presented. -CP #5 first day of work at facility was 2/13/21- no	V 536		

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V 536	Continued From page 68 NCI+ training certificate was presented. -CP #6 first day of work at facility was 2/16/21- no NCI+ training certificate was presented. -CP #7 first day of work at facility was 2/12/21 and trained on 3/2/21 -CP #8 first day of work at facility was 2/18/21 and trained on 3/2/21 -CP #9 first day of work at facility was 2/19/21- no NCI+ training certificate was presented. -CP #10 first day of work at facility was 2/14/21 and trained on 3/3/21 Interview on 3/15/21 with the coordinator for Healthcare Personnel agency #1 revealed: -Tapestry provided NCI training Interview on 3/11/21 with the Director of local healthcare personnel agency #2 revealed: -We just got the de-escalation training- NCI+ This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews the facility	V 736		

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V 736	Continued From page 69 failed to be maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 2/17/21 at 12:45pm of the facility revealed: -upstairs to the left is girls wing- male wing to the right -male wing -2 bedrooms- 2 beds in each room -new fob buttons inside bedrooms on opposite wall from door -bedroom #1- small hole from doorknob behind door -holes in wall in bedroom #2- 1-approximately 4" x 8" long and 2-behind the door approximately 14" long x 4" wide -Camera outside hallway door at top of stairs could view back towards boy's wing and down stairs -short hallway and through door into Blue Room -hole in wall in hallway approximately 4" x 4". -Bathroom on right before blue room -Girls hall- 6 bedrooms- 2 beds in each room, 1 bathroom -2 holes in hallway approx. 6" x 12" and 3" x 3" -2 patched holes not painted in hallway -2nd camera at end of hallway above group room-could view back down hallway Interview on 2/17/21 with Client #1 revealed: -"Guys punched holes in the wall-[FC #5] and [non-audited FC #8]." Interview on 2/17/21 with Client #3 revealed: -"The guys would hit the walls leaving holes." Interview on 3/4/21 with the Executive Director revealed: -Maintenance man was quarantined and couldn't fix. -There were plans for a contractor to remodel	V 736		

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V 736	Continued From page 70 group room downstairs and would fix walls then. -Thought they were supposed to start this week. This deficiency is cross referenced in 10A 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 736		