STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	R 10/27/2021

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TAPESTRY ADOLESCENT RESIDENTIAL PROGRAM	5030 HENDERSONVILLE ROAD FLETCHER, NC 28732

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 10/27/21. The complaints were unsubstantiated (NC00179044 and NC00179063). 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 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Record review on 10/14/21 of disaster drills conducted between October 2020 to September 2021 revealed: -no evidence of 2nd or 3rd shift disaster drills	V 114		

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V 114	Continued From page 1 from 10/1/20-12/31/20; -no evidence of a disaster drill on any shift (1st, 2nd or 3rd) from 4/1/21-6/30/21; -no evidence of a disaster drill on 1st shift from 7/1/21-9/30/21. Record review on 10/14/21 of fire drills conducted between October 2020 to September 2021 revealed: -no evidence that fire drills were conducted on any shift from 10/1/20 to 12/31/20; -no evidence of a fire drill on 3rd shift from 4/1/21 to 6/30/21. Review on 10/14/21 of Client #1's record revealed: -admission date of 9/20/21; -diagnoses of Other Specified Feeding or Eating Disorder (d/o); Generalized Anxiety d/o; Major Depressive d/o, recurrent, severe; Post Traumatic Stress Disorder; Obsessive Compulsive d/o; Unspecified Attention Deficit Hyperactivity d/o. Interview on 10/13/21 with Client #1 revealed: -she has not participated in fire or disaster drills since she was admitted; -"there is a sheet on the wall with the fire escape plan." Review on 10/14/21 of Client #2's record revealed: -admission date of 9/8/21; -diagnoses of Avoidant Restrictive Food Intake d/o provisional; Adjustment d/o with Anxiety, provisional. Interview on 10/13/21 with Client #2 revealed: -she has "heard that they have done" fire and disaster drills but she hasn't done one yet; -"there are fire safety plans by every door."	V 114		

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V 114	Continued From page 2 Interview on 10/14/21 with the Executive Director (ED) revealed: -the former Site Coordinator did the drills and she was unsure where she kept them; -she searched the former Site Coordinators desk and found fire and disaster drills reports.	V 114		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	V 366		

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V 366	Continued From page 3 (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose	V 366		

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V 366	Continued From page 4 catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure level III incident reports for sexual abuse/assault/rape allegations were completed for 2 of 2 former clients (FC #3 and FC #4). The findings are: Record review on 10/14/21 of FC #3 revealed:	V 366		

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V 366	Continued From page 5 -admission date of 6/10/21; -discharge date of 8/6/21; -diagnoses of Major Depressive Disorder, recurrent, severe, provisional; Post-Traumatic Stress Disorder; Generalized Anxiety Disorder. Record review on 10/14/21 and 10/21/21 of FC #4 revealed: -admission date of 6/21/21; -discharge date of 7/1/21; -diagnoses of Post-Traumatic Stress Disorder and Generalized Anxiety Disorder. Review on 10/13/21 and 10/27/21 of the North Carolina Incident Response Improvement System (IRIS) revealed: -2 Level III incidents on FC #3 and FC #4; -FC #3's incident was dated 6/27/21 with type of incident Sexual abuse/Assault/Rape checked; -the Health Care Personnel Registry (HCPR) section was incomplete; -items missing were the alleged staff member information, the investigation results, Department of Social Services information, Police information, complete details of the facility investigation, conclusions of the accused staff, and witnesses; -there were no preliminary findings and final investigation reports attached; -FC #4's incident was dated 6/30/21 with type of incident Sexual abuse/Assault/Rape checked; -the HCPR section was not completed; all sections were blank; -both above incident reports were completed by the Director of Performance Improvement. Interviews on 10/26/21 and 10/27/21 with the Director of Performance Improvement revealed: -facility internal incident reporting is electronic for Level I-III incidents; -he receives immediate notification in order to	V 366		

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V 366	Continued From page 6 review the report to determine whether it should be reported as a Level II or III incident and entered in to IRIS; -he enters the report if staff is unable to ensure it is entered within the 72 hour time frame; -he completed the reports for the Level III incidents for FC#3 and FC#4; -he acknowledged that he did not complete the HCPR section initially; -he did not know why it wasn't initially done "was waiting on it for a reason" but can't recall that reason; -after checking his notes, he was unable to clarify why the HCPR section was not completed but thinks that administrators and Human Resources may have wanted to take further steps in their investigation before entering the information; -he reviewed emails to see if he received one triggering him to complete the HCPR section or upload investigation documents but could not find one which could be attributed to the lapse in time since the initial report; -he is not sure if it's "miscommunication, missed an email or a call."	V 366		