Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL088-023	B. WING		F 05/1	R 0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAPEST	RY EATING DISORDE	R PROGRAM	H COUNTRY D, NC 28712	CLUB ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 000	V 000 INITIAL COMMENTS		V 000			
	completed on May were unsubstantiate	nt and follow up survey was 10, 2022. The complaints ed (Intake #NC00187259, I #NC00188304). Deficiencies				
	categories: 10A NC Hospitalization for I Mentally III and 10A	sed for the following service CAC 27G .1100 Partial ndividuals who are Acutely NCAC 27G .5600A or Adults with Mental Illness.				
	currently has a cent	gram is licensed for 6 and sus of 6. The day program sus of 4. The survey sample of 2 current clients and 1				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaste shall be held at leas repeated for each se under conditions the	207 EMERGENCY PLANS on for each facility and plan shall be developed and by the appropriate local on the made available to all staff cedures and routes shall be straightful or developed and routes shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL088-023	B. WING			R 10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE			
TAPEST	RY EATING DISORDE	R PROGRAM	TH COUNTRY RD, NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 114	facility failed to conquarterly for each services on 4-28-22 -Fourth quarter of 20 fire drills for first, services on quarter of drills for first or third first or third quarter of 20 fire drills for first or third first or third quarter of 20 fire drills for first sharp of the first quarter of 20 fire drills for first sharp of the first of	et as evidenced by: views and interviews, the duct fire and disaster drills chift. The findings are: of Fire Drill Logs revealed: 2021 (October - December) first, second, or third shift. 21 (July - September) had no econd, or third shift. 2021 (April - June) had no fire d shift. 22 (January - March) had no ift. of Disaster Drill Logs 2021 (October - December) Is for first, second, or third 21 (July - September) had no st, second, or third shift. 2021 (April - June) had no st, second, or third shift. 2 with Client #5 revealed: acility for one month. ed in a fire drill. re to go during a drill. 2 with Client #8 revealed: acility for just over a month. aintenance had come around to do and where to go.	e	DEFICIENC			
		n Director in September 2021 one regularly but they stoppe					

Division of Health Service Regulation

STATE FORM 6899 M11P11 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COME	(X3) DATE SURVEY COMPLETED			
		MHL088-023	B. WING			R 10/2022		
		•			05/	10/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH COUNTRY OF THE POAR								
TAPESTRY EATING DISORDER PROGRAM 11 NORTH COUNTRY CLUB ROAD BREVARD, NC 28712								
	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
in 20. -"I an Interv Presi -Had the fa -Mair and v -Thei	riew on 4-29-2 dent of Opera been the Vice acility since mintenance was were doing one re were no dis responsibility		V 114					

Division of Health Service Regulation

STATE FORM 6899 M11P11 If continuation sheet 3 of 3