PRINTED: 05/15/2024 Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL011-443 B. WING 05/13/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 882 ELIADA HOME ROAD **ELIADA TREATMENT CENTER** ASHEVILLE, NC 28806 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 V114 - Correction - Residential Director will initiate fire and disaster drills in the An annual survey was completed on May 13, current quarter during each shift. 2024. Deficiencies were cited. V114 - Prevention - Quality Assurance The facility is licensed for the following service Manager will create a calendar with category: 10A NCAC 27G .1700 Residential automated reminders prompting fire and Treatment Staff Secure for Children and disaster drills with a minimum of once Adolescents. per shift per quarter. This facility is licensed for 8 and has a current V114 - Monitoring - Quality Assurance census of 4. The survey sample consisted of Manager will have reminders from the audits of 2 current clients and 1 former client. automated calendar system to review that a fire or disaster drill was V 114 27G .0207 Emergency Plans and Supplies V 114 completed. Additionally, once per quarter, the Quality Assurance Manager 10A NCAC 27G .0207 EMERGENCY PLANS will complete an audit of the record of AND SUPPLIES fire and disaster drills. Any deficiencies (a) A written fire plan for each facility and found in internal monitoring will be area-wide disaster plan shall be developed and followed-up with a plan of correction. shall be approved by the appropriate local V131 - Correction - PQI Department (b) The plan shall be made available to all staff Staff will complete an audit of staff files and evacuation procedures and routes shall be and HR Staff will complete registries for posted in the facility. any found to be deficient. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be V131 - Prevention - Chief Compliance repeated for each shift. Drills shall be conducted Officer will create a process map of the under conditions that simulate fire emergencies. hiring/onboarding process with the HR (d) Each facility shall have basic first aid supplies Recruiter with the registries included as accessible for use. a step. Training will be completed by the PQI and HR department heads to ensure the HR Recruiter understands the process for running registries and

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quarterly for each shift. The findings are:

facility failed to hold fire and disaster drills at least

This Rule is not met as evidenced by: Based on record reviews and interviews, the

off for each new hire.

documenting results in HR files. A checklist of file requirements will be

created by CCO showing registries as a

required document that will be signed

(X6) DATE

STATE FORM

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 05/13/2024 MHL011-443 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 882 ELIADA HOME ROAD **ELIADA TREATMENT CENTER** ASHEVILLE, NC 28806 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 114 V131 - Monitoring - HR Director will V 114 Continued From page 1 conduct regular checks of new hire HR Review on 5/7/24 and 5/8/24 of the facility's fire files. This process will include and disaster drill log revealed: checking that registries have been run -No documentation of fire drills on first shift for in each file. Additionally, once per third quarter 2023 (July-September). guarter, the PQI RISE intern will -No documentation of fire drills on first shift for complete an audit of a sample of HR fourth quarter 2023 (October-December). files which will include new hires, staff -No documentation of fire drills on first shift for who had a work anniversary in the last first quarter 2024 (January-March). quarter, and staff terminated in the last -No documentation the clients were present for quarter. Any deficiencies found in disaster drills on first shift for third and fourth internal monitoring will be followed-up quarter 2023 (July-December) and first quarter with a plan of correction. 2024 (January-March). Interview on 5/13/24 with the Residential Director revealed: -"I make sure they (fire drills) are done." -"Documenting that it (disaster drills) is happening on campus but not necessarily in the cottage." Interview on 5/13/24 with the Chief Compliance Officer revealed: -Was the responsibility of the Residential Director to make sure drills were completed correctly. -The Quality Assurance Manager would check the fire and disaster drill logs. Interview on 5/13/24 with the Quality Assurance Manager revealed: -Disaster drills were completed even if no clients were present in the facility. -Would alternate who was responsible for completing the fire drills. V 131 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

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND I DIN OF SOMESTION	IDENTIFICATION NUMBER:	A. BUILDING	:		COMPLETED				
	MHL011-443	B. WING			05/13/2024				
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE						
882 FLIADA HOME POAD									
ELIADA TREATMENT CENTER	ASHEVILI	E, NC 28806							
PREFIX (EACH DEFICIENCY MUST	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE				
V 131 Continued From page 2 health care facility or service health care facility shall accepersonnel Registry and shall of access in the appropriate of access in the appropriate Registry (HCPR) check prior are: Review on 5/9/24-5/10/24 of #2's record revealed: -Date of Hire: 1/8/24Date of HCPR check: 5/7/2 Interview on 5/13/24 with the Officer revealed: -Human Resources was rescompleting and filing the HC-HCPR checks had been costaff hired the same day as if	denced by: denced by: d interview the facility h Care Personnel or to hire. The findings of Former Staff (FS) 44. e Chief Compliance ponsible for CPR checks. mpleted for other	V 131							

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING MHL011-203 05/13/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 111 COMPTON DRIVE REUTER COTTAGE ASHEVILLE, NC 28806 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)(EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 V114 - Correction - Residential Director will initiate fire and disaster An annual and complaint survey was completed drills in the current quarter during on May 13, 2024. The complaint was each shift. substantiated (Intake #NC00216640). A deficiency was cited. V114 - Prevention - Quality Assurance Manager will create a calendar with This facility is licensed for the following service automated reminders prompting fire category: 10A NCAC 27G .1700 Residential and disaster drills with a minimum of Treatment Staff Secure for Children or once per shift per quarter. Adolescents. V114 - Monitoring - Quality Assurance This facility is licensed for 6 and has a current Manager will have reminders from the census of 6. The survey sample consisted of automated calendar system to review audits of 4 current clients. that a fire or disaster drill was completed. Additionally, once per V 114 27G .0207 Emergency Plans and Supplies V 114 quarter, the Quality Assurance Manager will complete an audit of the 10A NCAC 27G .0207 EMERGENCY PLANS record of fire and disaster drills. Any AND SUPPLIES deficiencies found in internal (a) A written fire plan for each facility and monitoring will be followed-up with a area-wide disaster plan shall be developed and plan of correction. shall be approved by the appropriate local (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.

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This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to hold fire and disaster drills at least

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(X6) DATE

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Division o	f Health Service Regu	ation	T	1/	V2) DATE SLIBVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL011-203	B. WING		05/13/2024	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
		111 COM	PTON DRIVE			
REUTER (COTTAGE	ASHEVIL	LE, NC 28806			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETE DATE DATE	
V 114	Continued From page 1		V 114			
	quarterly for each shift. The findings are:					
	Review on 5/7/24 an	d 5/8/24 of the facility's fire				
	and disaster drill log	revealed:				
	-No documentation of	of fire drills on first shift for				
	third quarter 2023 (July-September).					
	-No documentation of fire drills on first shift for fourth quarter 2023 (October-December).			**		
	-No documentation of	of fire drills on first shift for				
	first quarter 2024 (January-March).					
	-No documentation the clients were present for					
	disaster drills on first shift for third and fourth quarter 2023 (July-December).					
	quarter 2025 (oury 2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Interview on 5/9/24 with the Residential Supervisor revealed: -Staff determined when fire drills were completed.					
	 -Was responsible to make sure drills were completed. 					
	Interview on 5/13/24 with the Residential Director revealed: -"I make sure they (fire drills) are done." -"Documenting that it (disaster drills) is happening					
	on campus but not	necessarily in the cottage."				
		4 with the Chief Compliance				
	Officer revealed: -Was the responsibility of the Residential Director					
	to make sure drills were completed correctly.					
	-The Quality Assurance Manager would check the					
	fire and disaster dri	II logs.				
	Interview on 5/13/2	4 with the Quality Assurance				
	Manager revealed:					
	-Disaster drills were completed even if no clients were present in the facilityWould alternate who was responsible for					
	-Would alternate w					

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