Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	ובט
		MHL004-016	B. WING		09/0	: 8/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CORNERS	STONE TREATMENT FAC	129 WALL	CE ROAD			
		WADESBO	PRO, NC 28170)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	00 INITIAL COMMENTS		V 000			
	8, 2020. The compla was substantiated. Do This facility is license category: 10A NCAC	d for the following service				
	Children and Adolesc	· · · · · · · · · · · · · · · · · · ·				
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	level II incidents, except the provision of billable consumer is on the princidents and level II to whom the provider 90 days prior to the ir responsible for the caservices are provided becoming aware of the besubmitted on a for Secretary. The report in person, facsimile of means. The report in formation: (1) reporting pridentification informat (2) client identification informat (3) type of incidentification of the incident; (4) description (5) status of the cause of the incident; (6) other individent incident; (7) other individent incident; (8) other individent incident;	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within ncident to the LME atchment area where I within 72 hours of the incident. The report shall m provided by the at may be submitted via mail, or encrypted electronic chall include the following ovider contact and cion; fication information; dent; of incident; e effort to determine the				

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

TITLE (X6) DATE

Division of Health Service Regulation

MHL004-016 B. WING		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 129 WALLCE ROAD WADESBORO, NC 28170 CAN ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE V 367 Continued From page 1 V 367 W 367 Continued From page 1 C 367 W 367 Continued From page 1 C 367 W 367 Continued From page 1 C 367 W 367 C 367 C 367 W 3	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 129 WALLCE ROAD WADESBORO, NC 28170 CAN ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE V 367 Continued From page 1 V 367 W 367 Continued From page 1 C 367 W 367 Continued From page 1 C 367 W 367 Continued From page 1 C 367 W 367 C 367 C 367 W 3							
NAME OF PROVIDER OR SUPPLIER CORNERSTONE TREATMENT FACILITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 1 missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provided postained information botained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's shall submit, and (3) the provider's response to the incident. (4) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. In cases of			MHI 004-016	B. WING		1	20
CORNERSTONE TREATMENT FACILITY 129 WALLCE ROAD WADESBORO, NC 28170				1		1 03/00/20	
(X4)ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CONFLICT CATCH CAND. CA	NAME OF PR	ROVIDER OR SUPPLIER			TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 1 Wissing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. In cases of	CORNERS	TONE TREATMENT FAC	CILITY				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 1 missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. In cases of			WADESBO	PRO, NC 28170)	<u> </u>	
missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of	PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	MPLETE
shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of	V 367	Continued From page	e 1	V 367			
client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the	V 367	missing or incomplete shall submit an update report recipients by the day whenever: (1) the provided information provided erroneous, misleading (2) the provided required on the incided unavailable. (c) Category A and B upon request by the Lobtained regarding the (1) hospital recipionism (2) reports by (3) the provided (4) Category A and B (5) and B (6) Category A and B (7) and B (8) and B (9) and B (9	e information. The provider led report to all required the end of the next business of the reason to believe that in the report may be gor otherwise unreliable; or robtains information ent form that was previously as providers shall submit, and the incident, including: ords including confidential enter authorities; and the rauthorities; and the rauthorities; and the roviders shall send a copy reports to the Division of commental Disabilities and rovices within 72 hours of the incident. Category A a copy of all level III client death to the Division of ation within 72 hours of the incident. In cases of the incident. In cases of the incident. In cases of the incident of the experimental send as a copy of all send as a copy of all send as a copy of the incident. In cases of the incident of the death of the services are provided. The services are provided the experimental on a form provided electronic means and shall the incident as follows:	V 367			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 2 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c
		MHL004-016	B. WING		09/08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
CODNED	STONE TREATMENT FAC	129 WALL	.CE ROAD		
CORNER	STONE TREATMENT FAC	WADESB	ORO, NC 28170		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 367	(3) searches of (4) seizures of the possession of a c (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter	el II or level III incident; a client or his living area; client property or property in lient; mber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that is as set forth in Paragraphs e and Subparagraphs (1)	V 367		
	failed to ensure a Lev completed and submit Entity/Managed Care within 72 hours. The factor of the report dated 6/19/20 are "[Client #2] was in the with [Executive Direct happened earlier and to be here. [Client #2] punch the wall. [Client self-reflection from an out [Client #2's] assig lobby and a 733 was and [Staff #8] in behir [Client #2] back to [Client #2]	ew and interview the facility el II incident report was tted to the Local Managed Organization (LME/MCO) indings are: The Facility's Level I Incident at 2:30 p.m. revealed: the self-reflection processing tor] about the incident that stated [Client #2] don't want begin to yell, scream, and the thind the diamade a left and walked the diamade a left and walked the diamade area going to the front called. [Executive Director] and [Client #2] and escorted			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 3 of 20

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		MHL004-016	B. WING		09/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		129 WALL	CE ROAD			
CORNERS	STONE TREATMENT FAC	CILITY	ORO, NC 28170)		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE CO	(X5) MPLETE DATE
V 367	Continued From page	e 3	V 367			
	_	tor] to escort [Client #2] to				
	her room. [Client #2]	cream stating [Client #2]				
		f monitoring [Client #2] and				
	_	.				
	[Client #2] grab a piece of clothing and					
	headphones and attempt to put it around [Client #2's] neck. First Responder [Staff #3] and Senior					
	First Responder [Staff #14] intervene to secure					
	the scene. [Clinical Director] notified all clients items removed to due to safety issues. Staff continued monitoring throughout the shift. Guardian was notified."					
	report dated 6/19/20 a - "[Client #2] became peers. [Client #2] wa not get her DVD playe [Client #2] was told to [Client #2] kicked wal closed bedroom door kicking and hitting stacelled and a 2-man thadministered for 15 m to calm down reach to processed with [client Review on 9/1/20 of the report dated 7/11/20 a - "While inside the coinformed staff that [Client the closet and retrieve informed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the closet and retrieve informed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the closet and retrieve informed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the staff and they would get the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinformed [Client #2] the report dated 7/11/20 a - "While inside the coinform	ninutes. [Client #2] was able ension reduction. Staff t #2] in [Client #2's] room." The Facility's Level II Incident at 8:40 p.m. revealed: Inference room, [Client #2] lient #2] wanted to go inside the bingo game. Staff that it is the responsibility of get it for [client #2]. [Client				
		d left the conference area #2's] room. While preparing				
		#2 sj room.				
	_	iff walked to [Client #2's]				
		e door in order to maintain a				
	direct line of site. [Cli					

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 4 of 20

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						;
		MHL004-016	B. WING		09/0	8/2020
			-			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		129 WALI	CE ROAD			
CORNERS	STONE TREATMENT FAC	CILITY	ORO, NC 28170	1		
		WADEOD	10,110 2017			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LOC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	DATE
				,		
V 367	Continued From page	<u>.</u> 4	V 367			
	oonanaoa i rom page					
	attempted to place ar	unknown object inside of				
	[Client #2's] clothing.	Staff inform supported staff				
		tions. Staff went to process				
		nt #2] became verbally				
		at staff to leave [Client #2]				
	00					
		Client #2's] room while				
		hand. Staff searched				
		ffects. While staff was				
	searching, [Client #2] became increasingly					
	verbally aggressive toward staff. [Client #2] got					
	up and attempted to d	grab clothes from staff.				
		nt #2's] personal items staff				
		dphone with exposed wire,				
	brown color pencil an	·				
	•					
	T	a package of hair that was				
		ed for contraband. When				
		ir, [Client #2] pushed and				
	kicked staff attempting	g to take the hair. [Client				
	#2] was placed in a tv	vo-man therapeutic hold				
	lasting two minutes u	ntil tension reduction was				
	met."					
	Interview on 9/3/20 w	ith Representative from				
	State Agency reveale					
	-She did not receive t	•				
	incident report dated					
		0 p.m. Level II incident				
	report dated 6/19/20	on 6/23/20.				
	-She received the 7/1	1/20 Level II incident report				
	on 7/15/20.					
		ident reports should be				
		ours or if on a Friday the				
	next working day.					
	HOAL WORKING day.					
	Interview on 0/0/20	ith the Executive Director				
		ith the Executive Director				
	revealed:					
	-Level I reports were					
	Administrative Assista	ant to complete Level II				
	reports.					
		ant was responsible for				
		•		<u> </u>		

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 5 of 20

Division of Health Service Regulation

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					C
		MHL004-016	B. WING		09/08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	-
			CE ROAD	,	
CORNERS	STONE TREATMENT FAC	CILITY	ORO, NC 28170)	
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	Al OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 367	√ 367 Continued From page 5		V 367		
	completing Level II reports and sending to appropriate agencies within 72 hours.				
V 517	517 27E .0104(c-d) Client Rights - Sec. Rest. & ITO		V 517		
	TIME-OUT AND PROFOR BEHAVIORAL Concentration intervel employed as a meaning retaliation by staff or for due to inadequacy interventions shall no causes harm or abus (d) In accordance with 27D, the governing be	AINT AND ISOLATION DIECTIVE DEVICES USED CONTROL entions shall not be s of coercion, punishment or for the convenience of staff of staffing. Restrictive t be used in a manner that e. th Rule .0101 of Subchapter ody shall have policy that estible use of restrictive			
	facility failed to (1)not intervention was utiliz for intervention made review/report of restri implement policies/pr reports to agencies a for one of three auditi are: Review on 9/1/20 of t report dated 6/19/20 a	ew and interviews the ify others when restrictive red; (2) assure authorization by a physician; (3) conduct ct intervention; (4) cocedures by submitting fter restrictive intervention red clients (#2). The findings the Facility's Level I Incident at 2:30 p.m. revealed:			
	with [Executive Direct happened earlier and	ne self-reflection processing tor] about the incident that stated [Client #2] don't want 2] begin to yell, scream, and			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 6 of 20

Division of Health Service Regulation

DIVISION	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B WING		С	
		MHL004-016	B. WING		09/08	3/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211		, ,			
CORNERS	STONE TREATMENT FAC	CILITY	LCE ROAD			
		WADESB	ORO, NC 28170)		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOLATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIL	5,2
					+	
V 517	Continued From page	e 6	V 517			
		-				
	-	nt #2] walked out of the				
		nd made a left and walked				
		ned area going to the front				
		called. [Executive Director]				
	•	nd [Client #2] and escorted				
		lient #2's] room. First				
		on the scene witched out				
	-	tor] to escort [Client #2] to				
	her room. [Client #2]	in [Client #2's] room				
	continue to yell and s	cream stating [Client #2]				
	want her family. Staf	f monitoring [Client #2] and				
	[Client #2] grab a pied	ce of clothing and				
	headphones and atte	mpt to put it around [Client				
	#2's] neck. First Resp	ponder [Staff #3] and Senior				
	First Responder [Staf	ff #14] intervene to secure				
		irector] notified all clients				
	_	e to safety issues. Staff				
	continued monitoring	throughout the shift.				
	Guardian was notified	•				
	-There was no level II	I report completed.				
	-There was no level II					
	received by the appro	•				
	-There was no docum					
		ed, time and discussion.				
	•	nentation of follow-up care				
	with the therapist.	•				
		ntial staff shift notes to				
		ughout the shift and day.				
		ented by Registered Nurse				
	#2 indicated follow-up					
		e notes after the restraint.				
		nce of debriefing with client				
	#2 and staff.	J. Godinening With Onlone				
	"E and stall.					
	Review on 9/1/20 of t	he Facility's Level II Incident				
		at 5:00 p.m. revealed:				
	•	at 5.00 p.m. revealed. angry, loud and cursing at				
	= =					
		s upset because she could				
		er due to safety issues.				
	[Cilent #2] was told to	go to [Client #2's] room.				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 7 of 20

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COM	-LETED	
						С	
		MHL004-016	B. WING	-	09	/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE			
TO THIS COLUMN	NOVIDEN ON OUT FEEL		.CE ROAD	12,211 0002			
CORNERS	STONE TREATMENT FAC	CILITY	ORO, NC 28170				
	CLIMMA DV CT		·		CORRECTION	0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 517	Continued From page	e 7	V 517				
	closed bedroom door kicking and hitting state called and a 2-man the administered for 15 m to calm down reach to processed with [client -Level I incident report the restraint. -Level II incident was appropriate agencies -There was no docum guardian was contact -There was no docum with the therapist. -There was no reside monitor client #2 through	ninutes. [Client #2] was able ension reduction. Staff #2] in [Client #2's] room." rt did not indicate reason for not submitted and received until 6/23/20.					
	report dated 7/11/20 a - "While inside the col informed staff that [CI the closet and retrieve informed [Client #2] th staff and they would g #2] became upset and and went into [Client #2 consumers to go to th outdoor activities, star room and opened the direct line of site. [Client attempted to place an [Client #2's] clothing. of the [Client #2's] act with [Client #2]. [Clie aggressive shouting a alone and get out of [nference room, [Client #2] iient #2] wanted to go inside the bingo game. Staff nat it is the responsibility of get it for [client #2]. [Client d left the conference area #2's] room. While preparing he recreation area to enjoy ff walked to [Client #2's] door in order to maintain a					

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 8 of 20

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL004-016	B. WING		C 09/08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CODNED	STONE TREATMENT EAC	129 WALL	CE ROAD		
CORNER	STONE TREATMENT FAC	WADESBO	RO, NC 28170)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETI
V 517	Continued From page	e 8	V 517		
V 517	searching, [Client #2] verbally aggressive to up and attempted to go While searching [Clieremoved broken head brown color pencil an attempted to search a on the [Client #2's] be staff picked up the hakicked staff attemptin: #2] was placed in a to lasting two minutes unmet." -Level II incident was by appropriate agencation -There was no docum guardian was contact. There was no reside monitor client #2 through -Level I or Level II did restraining client #2. -Level I or Level II did restraining client #2. -Level I indicated tele 7/11/20 by the medication -There was no evident telephone verbal order telephone verbal order telephone telephone verbal order telephone verbal order telephone verbal order telephone verbal order [Client #2] was in nothe Clinical Director and [Client #2] walked to place to beat on the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the word was provided in the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was beating on the wall in Staff approached [Client was be	became increasingly oward staff. [Client #2] got grab clothes from staff. Int #2's] personal items staff dphone with exposed wire, done marker. Staff a package of hair that was ed for contraband. When air, [Client #2] pushed and got take the hair. [Client wo-man therapeutic hold intil tension reduction was not submitted and received ies until 7/15/20. Inentation client #2's ed, time and discussion. Inentation of follow-up care intial staff shift notes to ughout the shift and day. I not identify staff involved in phone order for restraint on all doctor. Increase the doctor signed the er within 24 hours. The Facility's Level II Incident at 9:08 p.m. revealed: ursing station speaking to bout prior altercation. [Client #2's] room and began an aggressive manner. ent #2] room and asked who all the peer stated the [Client in pass staff and hit peer in	V 517		
	was beating on the w #2] did. [Client #2] ra the face. Staff interve	all the peer stated the [Client			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 9 of 20

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL004-016	B. WING		09/08/2020
					1 00:00:2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
CORNERS	STONE TREATMENT FAC	CILITY 129 WAI	LCE ROAD		
		WADES	BORO, NC 28170		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	
IAG		,	IAG	DEFICIENCY)	
		_	1/547		
V 517	Continued From page	9	V 517		
	#2] kicked leg and hit	staff in the face and ran			
	down the hall to the community area. Staff was notified by the Clinical Director to call the police.				
	,	d processed with [Client #2].			
		gard, remorse or respect for			
		ntinued to process with			
		itely one hour. [Client #2]			
		s going to throw water at			
		direct [Client #2's] actions.			
	[Client #2] picked up				
	-	at staff. Staff was able to			
		ng the water from splashing			
	on staff. [Client #2] b				
	_ =	nd biting staff. [Client #2]			
		nerapeutic hold for 5 minutes			
	[n had been reached. [Client			
	#2] became verbally	aggressive toward staff.			
	[Client #2] walked over	er to staff attempting to hit			
	staff. Staff prevented	I consumer from hitting staff.			
	[Client #2] became up	pset and grabbed staff's eye			
		and broke them. [Client #2]			
	attempted to assault	staff again by walking up to			
		was approaching staff,			
		the water that [Client #2]			
		[Client #2's] head on the			
		[Client #2's] head and			
		ontinued to process with			
		#2] performed a physical			
	assessment."				
	-There was no docum				
	•	ted, time and discussion.			
		nentation of follow-up care			
	with the therapist.	main a saff a laife and a s			
		ntial staff shift notes to			
		ughout the shift and day.			
		phone order for restraint on			
	7/13/20 by the medic				
	telephone verbal orde	nce the doctor signed the er within 24 hours.			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 10 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
,	o. oo2011011	.52.111671.16.11.1652.11.	A. BUILDING:			
						С
		MHL004-016	B. WING		09	/08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CODVED	270NE TREATMENT EA	129 WAI	LLCE ROAD			
CORNER	STONE TREATMENT FAC	WADES	BORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETE DATE
				DEFICIEN	CY)	
V 517	Continued From page	e 10	V 517			
	Interview on 9/3/20 w	vith Representative from				
	State Agency reveale					
	-She did not receive t					
	incident report dated					
	-She received the 5:00 p.m. Level II incident report dated 6/19/20 on 6/23/20.					
	-She received the 7/11/20 Level II incident report					
	on 7/15/20.					
	-She reported the inc	ident reports should be				
	submitted within 24 hours or if on a Friday the next working day. Interview on 9/8/20 with the Executive Director					
	revealed:					
	-Level I reports were submitted to the					
	· ·	ant to complete Level II				
	reports.	•				
	-Administrative Assis	tant was responsible for				
		eports and sending to				
	appropriate agencies					
		linical director to submit				
	therapy notes regard care with client #2.	ing restraints and follow-up				
		ours to sign telephone				
	verbal restraint orders					
		ential shift notes provided				
	upon exit.					
	•	al notes from the clinical				
	director provided upo	on exit.				
	-She confirmed reque	esting clinical notes from the				
	clinical director.					
		split time with the company's				
		not always at the facility.				
	-She would be the pe					
	_	than 1 hour of the restraint				
	or between 1-2 hours					
	_	ot have documentation to				
		vith client #2's guardian.				
		all identified issues and				
	Louiceius with direct (care and professional staff.	1 1			

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 11 of 20

Division of Health Service Regulation

	n riealth Service Regu	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	EΠ
					С	
		MHL004-016	B. WING		09/08/	/2020
		WINL004-016			1 09/06/	72020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		129 WAL	LCE ROAD			
CORNERS	STONE TREATMENT FAC	CILITY WADESB	ORO, NC 2817)		
040.15	QUMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
V E26	07E 0407 Olicat Dial	ota Turinina en Alta Dest	V 526			
V 536		nts - Training on Alt to Rest.	V 536			
	Int.					
	10 A NCAC 27E 010	7 TRAINING ON				
	10A NCAC 27E .0107					
	ALTERNATIVES TO RESTRICTIVE					
	INTERVENTIONS	mlamant maliaiaa amd				
	(a) Facilities shall im					
	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					
	demonstrate compete					
		communication skills and				
		reating an environment in				
		f imminent danger of abuse				
		with disabilities or others or				
	property damage is p					
		s shall establish training				
	-	etencies, monitor for internal				
	-	onstrate they acted on data				
	gathered.					
		be competency-based,				
	include measurable le					
		vritten and by observation of				
	,	ejectives and measurable				
	methods to determine	e passing or failing the				
	course.					
	` '	training must be completed				
	•	der periodically (minimum				
	annually).					
	(f) Content of the train	_				
		nploy must be approved by				
	the Division of MH/DI					
	Paragraph (g) of this					
		strate competence in the				
	following core areas:					
		and understanding of the				
	people being served;					
		and interpreting human				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 12 of 20

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		MHL004-016	B. WING		09/08/2020	
NAME OF D		CTDEET /	DDDECC CITY CTA	TE 710 000E	•	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	TE, ZIP CODE		
CORNERS	STONE TREATMENT FAC	CILITY	LCE ROAD			
	I	WADES	BORO, NC 28170			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI	(- /	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF		
				DEFICIENCY)		
V 536	Continued From page	- 12	V 536			
V 330	Continued From page	e 12	V 330			
	behavior;					
		the effect of internal and				
		at may affect people with				
	disabilities;					
		or building positive				
	relationships with per					
		cultural, environmental and				
	_	s that may affect people with				
	disabilities; (6) recognizing	the importance of and				
		n's involvement in making				
	decisions about their					
		essing individual risk for				
	escalating behavior;	ooonig marriada. Hek ter				
		tion strategies for defusing				
		tentially dangerous behavior;				
	and	-				
		navioral supports (providing				
		h disabilities to choose				
	activities which direct	• • • •				
	behaviors which are	,				
	(h) Service providers					
		ial and refresher training for				
	at least three years. (1) Documenta	tion shall include:				
		nated in the training and the				
	outcomes (pass/fail);	ated in the duning and the				
		vhere they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualific	ations and Training				
	Requirements:					
		all demonstrate competence				
		esting in a training program				
		reducing and eliminating the				
	need for restrictive in					
	` '	all demonstrate competence				
	by scoring a passing	grade on testing in an				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 13 of 20

Division of Health Service Regulation

DIVISION	of Health Service Regu	ilation			_				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED				
			-						
		D. WING		С					
		MHL004-016	B. WING		09/08/2020				
NAME OF D		STDEET A	DDDEEC CITY CTA	TE 710 CODE					
NAME OF FI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
CORNERS	STONE TREATMENT FAC	CILITY	LCE ROAD						
		WADESE	BORO, NC 28170)					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)				
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE				
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE				
				DEFICIENCY)					
V 536	Continued From page	<u>-</u> 13	V 536						
	Continuou i rom page	3 10							
	instructor training pro	gram.							
	(3) The training	g shall be							
	competency-based, in	nclude measurable learning							
		ole testing (written and by							
	-	ior) on those objectives and							
		to determine passing or							
	failing the course.	to dotormine passing of							
	•	t of the instructor training the							
	service provider plans								
		sion of MH/DD/SAS pursuant							
	to Subparagraph (i)(5								
		instructor training programs							
		not limited to presentation of:							
		ng the adult learner;							
	(B) methods fo	r teaching content of the							
	course;								
	(C) methods fo	r evaluating trainee							
	performance; and								
	(D) documentat	tion procedures.							
	(6) Trainers sha	all have coached experience							
	teaching a training pr	ogram aimed at preventing,							
	reducing and eliminat	ting the need for restrictive							
	interventions at least	one time, with positive							
	review by the coach.								
	•	all teach a training program							
		reducing and eliminating the							
		terventions at least once							
	annually.	torronnione at loadt ones							
	-	all complete a refresher							
	instructor training at l	•							
	(j) Service providers								
		ial and refresher instructor							
	training for at least th	<u> </u>							
	` '	entation shall include:							
	• • • • • • •	pated in the training and the							
	outcomes (pass/fail);								
	• •	where attended; and							
	(C) instructor's								
	(2) The Division	n of MH/DD/SAS may							

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 14 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL004-016	B. WING		09	C 9/08/2020
NAME OF D				7/0.0005	1 00	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
CORNERS	STONE TREATMENT FAC	CILITY	LCE ROAD BORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 536	J	e 14 is documentation any time.	V 536			
	(k) Qualifications of (1) Coaches sh requirements as a tra (2) Coaches sh the course which is book (3) Coaches sh competence by comp train-the-trainer instru	Coaches: all meet all preparation iner. all teach at least three times eing coached. all demonstrate letion of coaching or				
	failed to ensure 2 of #13) received recertif to Restrictive Interver Review on 9/8/20 of S revealed: -Hire date of 8/12/18Employed as Reside -Crisis Prevention Interver	as evidenced by: ew and interview, the facility 13 audited staff (#8 and ication training in Alternative ations. The findings are: Staff #8 personnel record Intial Mental - 2nd shift. Ervention expired 8/6/20. It CPI training certification in				
	revealed: -Hire date of 9/1/19Employed as Reside shiftCrisis Prevention Into	Staff #13 personnel record ntial Mental - 2nd and 3rd ervention expired 8/3/20. t CPI training certification in				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 15 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL004-016	B. WING		09	C / 08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CORNERS	STONE TREATMENT FAC	'II ITV	LCE ROAD			
OOMINEM	TONE TREATMENT TA	WADESI	BORO, NC 28170			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 536	Continued From page	e 15	V 536			
	the personnel record.					
	revealed: -The agency trained s by the facility's first re responderThe administrative a keep track when it wa	staff on CPI and facilitated esponder and senior first essistant was supposed to as time for recertifications. and #13 CPI training expired.				
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the property to these procedures. Staff authorized to emprocedures are retrain competence at least a (b) Prior to providing disabilities whose traincludes restrictive into service providers, empoly to the service providers, empoly training is completed demonstrated. (c) A pre-requisite for demonstrating competers in preventing the need for restrictive in the service providers.	CAL RESTRAINT AND JT ral restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including aployees, students or olete training in the use of estraint and isolation time-out se interventions until the and competence is r taking this training is etence by completion of a reducing and eliminating				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 16 of 20

Division of Health Service Regulation

DIVISION	n Health Service Negu	lation							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED					
				C	;				
		MHL004-016	B. WING		09/0	8/2020			
			•						
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE					
CODNED	129 WALLCE ROAD								
CORNERSTONE TREATMENT FACILITY WADESBORO, NC 28170									
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(VE)			
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE			
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE			
				DEFICIENCY)					
V 537	Continued From page	e 16	V 537						
	inaluda maaaurahla la	arning chicatives							
	include measurable le	•							
	- ,	vritten and by observation of							
	•	ejectives and measurable							
	methods to determine	e passing or failing the							
	course.								
	(e) Formal refresher	training must be completed							
	by each service provi	der periodically (minimum							
	annually).								
	(f) Content of the trai	ning that the service							
		ploy must be approved by							
	the Division of MH/DE								
		•							
	Paragraph (g) of this								
		ng programs shall include,							
	but are not limited to,	presentation of:							
	(1) refresher inf	formation on alternatives to							
	the use of restrictive i	nterventions;							
	(2) guidelines of	on when to intervene							
		nent danger to self and							
	others);	3							
	, ,	n safety and respect for the							
	. ,	Ill persons involved (using							
		rictive interventions and							
	· · · · · · · · · · · · · · · · · · ·								
	incremental steps in a								
	` '	or the safe implementation							
	of restrictive intervent	-							
		mergency safety							
	interventions which in	clude continuous							
	assessment and mon	itoring of the physical and							
	psychological well-be	ing of the client and the safe							
		ghout the duration of the							
	restrictive intervention	-							
	(6) prohibited p	•							
		trategies, including their							
	importance and purpo								
		tion methods/procedures.							
	(h) Service providers								
		al and refresher training for							
	at least three years.								
	(1) Documenta	tion shall include:							

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 17 of 20

Division of Health Service Regulation

DIVISION	n nealth Service Negu	ilation			ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			D MANAGE		C	
		MHL004-016	B. WING		09/08/2020	
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIR CODE		
IVAIVIL OI II	NOVIDER OR GOLT EIER			11 L, ZII OOBL		
CORNERS	STONE TREATMENT FAC	CILITY	CE ROAD			
		WADESB	ORO, NC 28170)		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NATE	
V 537	Continued From page	e 17	V 537			
	(Λ)ls a mantisim	atad in the tunining and the				
		pated in the training and the				
	outcomes (pass/fail);					
		vhere they attended; and				
	(C) instructor's					
	` '	n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualification	ation and Training				
	Requirements:					
		all demonstrate competence				
	,	esting in a training program				
	aimed at preventing,	reducing and eliminating the				
	need for restrictive inf	terventions.				
	(2) Trainers sha	all demonstrate competence				
	by scoring 100% on to	esting in a training program				
	teaching the use of se	eclusion, physical restraint				
	and isolation time-out	t.				
	(3) Trainers sha	all demonstrate competence				
	* *	grade on testing in an				
	instructor training pro	-				
	(4) The training					
	` '	nclude measurable learning				
		le testing (written and by				
	_	ior) on those objectives and				
		to determine passing or				
	failing the course.	F-20119 01				
	•	t of the instructor training the				
	service provider plans					
	-	sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6					
		instructor training programs				
		be limited to, presentation				
	of:	be inflited to, presentation				
		ng the adult learner;				
	. ,	r teaching content of the				
	` '	r teaching content of the				
	course;	of trained performance and				
		of trainee performance; and				
	• •	ion procedures.				
	()	all be retrained at least				
	annually and demons	strate competence in the use				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 18 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL004-016	B. WING		C 09/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CORNERS	STONE TREATMENT FAC	CILITY	_CE ROAD ORO, NC 28170	n		
	CUMMA DV CT				DN	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETE	
V 537	Continued From page	e 18	V 537			
V 537	of seclusion, physical time-out, as specified Rule. (8) Trainers shows the correction of the correcti	restraint and isolation in Paragraph (a) of this all be currently trained in all have coached experience f restrictive interventions at a positive review by the all teach a program on the rventions at least once all complete a refresher east every two years. Is shall maintain fal and refresher instructor free years. Ition shall include: Frated in the training and the where they attended; and frame. In of MH/DD/SAS may focumentation at any time. Froaches: Fraull meet all preparation finer. Fraull teach at least three for is being coached. Fraull demonstrate folietion of coaching or fraction. Fraull be the same	V 53/			
	This Rule is not met	as evidenced by:				

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 19 of 20

Division of Health Service Regulation

	i Health Service Regu		1		1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
]		
			D 14/11/2		С
		MHL004-016	B. WING		09/08/2020
NAME OF D	DOVIDED OD CURRUIED	OTDEET ADE	ADECC CITY CTA		
NAME OF PH	ROVIDER OR SUPPLIER		RESS, CITY, STA	NE, ZIF CODE	
CORNERS	STONE TREATMENT FAC	CILITY 129 WALL	CE ROAD		
OOKINEKO	TONE INCAMBENTIAC	WADESBO	RO, NC 28170)	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
V/ F07	0 " 15	40	14.507		
V 537	Continued From page	e 19	V 537		
	Based on record revie	ew and interview the facility			
		I3 audited staff (#8 and #13)			
		,			
		ion, physical restraint and			
	isolation time-out. Th	ne finding are:			
	D	o. # #0			
		Staff #8 personnel record			
	revealed:				
	-Hire date of 8/12/18.				
	-Employed as Reside	ential Mental - 2nd shift.			
	-Crisis Prevention Inte	ervention expired 8/6/20.			
		t CPI training certification in			
	the personnel record.				
	po				
	Review on 9/8/20 of 9	Staff #13 personnel record			
	revealed:	otali #10 persorinei record			
	-Hire date of 9/1/19.				
		ential Mental - 2nd and 3rd			
	shift.				
		ervention expired 8/3/20.			
	-There was no curren	t CPI training certification in			
	the personnel record.				
	•				
	Interview on 9/8/20 w	ith the Executive Director			
	revealed:				
		staff on CPI and facilitated			
	• .	esponder and senior first			
	responder.	opender and sellior illst			
	· ·	cointant was supposed to			
		ssistant was supposed to			
	•	as time for recertifications.			
	-Confirmed staff #8 a	nd #13 CPI training expired.			
			1		

Division of Health Service Regulation

STATE FORM 6899 G4HJ11 If continuation sheet 20 of 20