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	MHL004-016	A. BUILDING: _____ B. WING _____	C 11/10/2020

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on November 10, 2020. The complaint was substantiated (intake #NC00170720). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1900 Psychiatric Residential Treatment Facility for Children and Adolescents	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to follow the written policy for discharge. The findings are: Review on 11/9/20 of the facility's policies revealed: -The policy for Discharge/Transfer from a Residential Facility had the following: "Cornerstone Treatment Facility shall not discharge or transfer any resident from a facility except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person...The [Qualified Professional and Clinical Director] will, in consultation with [Executive Director], develop a plan for discharging the client. Every effort will be made to maintain the client for a sufficient period of time to allow the legally responsible person to obtain alternative resources." Review on 11/9/20 of former client (FC #12) record revealed: - Admission date of 11/19/19 - Diagnoses of Disruptive Mood Dysregulation Disorder, Conduct Disorder, Child Sexual Abuse, Cannabis Use Disorder and Attention Deficit Hyperactivity Disorder. - Age 16 -Discharge date 9/21/20 -Discharge Report dated and signed 9/22/20 by the Executive Director had the following. FC #12 was being discharged due to maximum benefit termination. "[FC #12] continues to face challenges with compliance and anger management at this time. [FC #12] remains physically and verbally aggressive with staff and peers. She has become a complete disruption to	V 105		

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her and peer's overall treatment, safety and overall healthy emotional wellbeing. She is not interested in getting better at this time and refuses to actively work on her treatment or the betterment of her overall mental health...Current recommendation is lateral Psychiatric Residential Treatment Facility (PRTF) transition. Department of Social Services/Managed Care Organization (DSS/MCO) was made aware on 8/25/20 that lateral Psychiatric Residential Treatment Facility (PRTF) will begin to be sought. Psychiatric Residential Treatment Facility (PRTF) continued to seek lateral Psychiatric Residential Treatment Facility (PRTF) placement however client was involuntarily committed (IVC'd) on 9/19/20 and no provider has been identified. [FC #12] was discharged on 9/21/20 due to: Encouraging other peers to fight; peers report feeling unsafe with her; excessive fighting staff and peers, continued to be very disruptive and aggressive within out therapeutic milieu. She posed a threat to majority of our clients and even staff. Lack of compliance with rules, bullying peers. It continues to be recommended that client be in Psychiatric Residential Treatment Facility (PRTF) placement. [FC #12] was seen by psychiatrist at [Name of local hospital] under involuntarily committed (IVC) and deemed inappropriate for ongoing hospitalization. Department of Social Services discharged [FC #15] from hospital on 9/21/20."

Interview with the Assistant Clinical Director on 11/10/20 revealed:
-FC #12 reason for discharge was that she had met maximum benefit.
-They had pretty much exhausted all of the ways to ensure FC #12 got services needed to address her aggression.
-FC #12's guardian was made aware of the issues and that FC #12 would be discharged at

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the end of September 2020.
-She thought she emailed FC #12's Guardian to inform her about the discharge.
-FC #12's guardian was told, FC #12 would be discharged on 9/30/20.
-During the treatment team meetings on September 3 and 17, it was reiterated that FC #12 was being discharged at the end of September 2020.
-She thought FC #12's guardian was on the call on September 17th, but she was not sure about September 3rd.
-They had been looking for placement for FC #12, but were unsuccessful.
-FC #12 was going to be discharged at end of month whether they found placement or not.
-There were several emails and conversations via telephone about the discharge and places for FC #12 to be transferred.
-She could not find placement within that timeframe.
-There were several barriers she faced trying to find placement.
-When FC #12 went to the hospital on 9/21/20 due to her behaviors, they decided to discharge her before the discharge date of 9/30/20.
-They did not do a written discharge notice for FC #12 prior to the discharge on 9/21/20.
-The guardian was not given a discharge notice in writing for FC #12 prior to the discharge.
-They normally would do a notice of discharge letter for the parent or guardian.
-In this case they emailed and called the treatment team for FC #12 about her discharge.
-She confirmed the facility failed to follow the written policy for discharge.

Interviews with the Executive Director on 11/9/20 and 11/10/20 revealed:
-She thought FC #12 left the facility in September

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V 105	Continued From page 5 2020. -She was discharged due to fighting staff and clients. -FC #12 made threats to kill all the clients in their sleep. -She was bullying most of the clients. -Her behaviors were too aggressive and out of control. -The police were called because FC #12 tried to hit another client with a chair. -One of the former clients tried to jump in, the other clients were upset and afraid. -FC #12 was trying to fight staff and peers. -Once the police arrived, FC #12 was still out of control. -FC #12 she was fighting two other clients. -FC #12 was handcuffed by the police and they recommended she be involuntarily committed. -FC #12 was admitted to a local hospital. -They had already planned to be discharge FC #12 from the facility. -They decided to discharge her once she went to the hospital. -The Clinical Team here decided to discharge her earlier than expected. -She was originally supposed to be discharged on Sept 29, 2020. -Once FC #12 left the hospital her guardian picked her up. -She was not sure what happened from their because the guardian was looking for placement. -FC #12 was supposed to be a lateral move from this Psychiatric Residential Treatment Facility (PRTF) to another PRTF. -She really was not the person responsible for doing the discharge notice prior to a client being discharged. -The Assistant Clinical Director or Clinical Director would normally be responsible for that process. -They would be responsible for sending the	V 105		

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V 105	Continued From page 6 written discharge notice to the clients parent or guardian. -She was not sure if the Assistant Clinical Director or Clinical Director sent a written notice of discharge to FC #12's guardian. -She confirmed the facility failed to follow the written policy for discharge.	V 105		
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 interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 11/10/20 at approximately 8:40 AM of the facility revealed the following issues: -Hallway/Common Area-There was tape on the floor, there were approximately 15 strips. -Clients #7 and #5 bedroom-There was sticker residue on the plexiglass window. There was a set of broken blinds. There were playing cards, papers, notebooks, stuffed animals and clothes on the floor. -Client #10's bedroom-The paint was peeling off the wall. -Bathroom A-The paint was peeling from wall in	V 736		

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V 736	Continued From page 7 two areas. The paint was two different colors on wall. There was a missing tile on floor. -Client #8's bedroom-There was sticker residue on the plexiglass window. There were shoes, papers, books, notebooks, playing cards and puzzles on the floor. There was paint peeling near the bedroom door. -Client #1's bedroom-There was a broken set of blinds. There was a white and two brownish spots on wall. There were pictures, paper, books, and pencils on the floor. -Bathroom B-There was peeling paint underneath the light switch. There were particles of dirt and dust on the floor behind the toilet area. -Client #11's bedroom-There were playing cards, shoes, papers and books on the floor. -Client #9's bedroom-There were puzzle pieces, paper, trash and clothes on the floor. -Bathroom C-There was writing on the door. The paint was peeling on the walls. -Client #2's bedroom-There was a broken set of blinds. The ceiling vent had a portion of the metal missing. There was sticker debris on the plexiglass window. The bedroom door had sticker debris on it. -Client #6's bedroom- The inside of closet wall had peeling paint. There was sticker debris on the plexiglass window. -The back door to the facility would not close all the way. The opening was approximately three inches wide. Interview with the Executive Director on 11/10/20 revealed: -She knew the back door to the the facility would not close all the way. -Two former clients were responsible for the back door being that way, they kept kicking it. -A maintenance person came out and said the door needed to be replaced.	V 736		

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V 736	Continued From page 8 -The maintenance person could not fix the back door. -She thought the door has been broken for about a month. -She was aware of most of the issues with the facility. -She has put in some work orders for the issues with the facility. -Some of the issues were addressed, but others were not. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		