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	MHL004-016	A. BUILDING: _____ B. WING _____	C 01/12/2022

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CORNERSTONE TREATMENT FACILITY	129 WALLCE ROAD WADESBORO, NC 28170

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V 000	INITIAL COMMENTS An annual, complaints (3) and follow up was completed on January 12, 2022. Two of the complaints were substantiated (intake #NC00184758, #NC00184173). One of the complaint was unsubstantiated (intake #NC00184826). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 PRTF-Psychiatric Residential Facility for Children and Adolescents. The survey sample consisted of audits of 7 current clients and 3 former clients.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident;	V 367		

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(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any 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 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.

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V 367	Continued From page 2 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 definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Level II incident report was completed and submitted to the Local Managed Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 1/10/22 of Client #1's record revealed: -Admission date of 7/15/21. -Diagnoses of Disruptive Mood Dysregulation Disorder; Conduct D/O, Unspecified onset type; ADHD Combined presentation (per history). Review on 1/10/22 of Client #3's record revealed:	V 367		

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-Admission date of 7/1/21.
-Diagnoses of Unspecified Bipolar Disorder; Conduct D/O, Childhood onset type; ADHD; Psychological Abuse (per client hx); Child Physical Abuse (per client hx); Child Neglect (per client hx); Child sexual Abuse (per client hx); PTSD.

Review on 1/10/22 of the Facility's Incident Reports Notebook revealed:
-Report dated 12/30/21.
-Report completed by the Facility Nurse.
-Incident Report identified as Level II.
-Clients #1 and #3 were restrained for 5 minutes.
-Any complications resulting from intervention: Client #1 had generalized pain. Tylenol given 9:18 com with diagnose of pain. Client request.

Review on 1/10/22 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II incident reports for Clients #1 and #3 for the months of December 2021 through January 2022.

Interview on 1/10/22 with Client #1 revealed:
-She reported that on 12/30/21, she was restrained. "It was a two staff restraint." One of the two staff (#11) pushed her elbow up after placing her arm in the back. She asked the nurse for some ice afterwards, but was given Tylenol.
-Next day, she was still hurting and they then took her to the hospital.
-Hospital said that she had a broken elbow and they were going to report the incident to social services after she told them what happened.

Interview on 1/10/22 with Client #3 revealed:
-She reported that on 12/30/21, she was also restrained.
-Staff placed Client #1's hands behind her back.

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-She did not know if staff may had pushed Client #1's hands up while restrained.

Interview on 1/10/22 with Staff #11 revealed:
-On 12/30/21, girls had been fighting and clients had to be restraint.
-Staff #11 also mentioned that one of the clients had dumped hand sanitizer on the floor and many of the girls had slipped and fallen to the floor. Including Client #1.
-Client #1 was pushed down by one of the other girls as she was falling.
-Client #1 continued to fight afterwards and had to be restrained again.
-Staff #11 did not know how Client #1 got hurt.
-She denied placing Client #1's hands behind her back.
-Staff #11 demonstrated restraint. Staff #11 reported that she brought Client #1 ' s arm to her side and placed her hip in between while holding on to her arm.
-Staff #11 reported that she received disciplinary action from the Director of Operations and all 2nd shift staff were retrained on physical interventions.

Interview on 1/10/22 with the Executive Director (ED) revealed:
-As an ED, she makes sure that incidents related to restraints are sent to the Vice President of Operations.
-Whenever there's an allegation of abuse, she investigated by talking to staff and children to find out what happened.
-Anything related to abuse, she would send the information up the chain of command to the Vice President of Operations.
-Whenever there's an incident related to restraints, they have 24 hours to submit paperwork to the Vice President of Operations.

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-She did not not know how Client #1 got hurt in the elbow as she was on vacation and did not return until 1/4/22.
-When she returned to work, she was told that the girls were getting for bed time and some started fighting. Staff broke off the fight. -The behaviors continued. Nurse tried to remove one of the clients that had been jumped on by others. She took her to her office and the others continued to follow her there.
-There was hand sanitizer on the floor as one of the girls had poured it there to make it slippery. Some of the girls felled because of the liquid on the floor, including Client #1.
-Client #1 was placed on a therapeutic hold as she was being aggressive to staff and other client. After the incident, Client #1 reported elbow hurting and nurse gave her pain medication. She went to sleep and the next day, she continued to complaint about her elbow hurting.
-Client #1 was then taken to the hospital to have elbow checked out.
-She did not know why the incident report was not submitted by the Vice President of Operations to the IRIS website.
-Since she was out on vacation when the incident occurred, the Director of Operations conducted investigation on what occurred.
-She acknowledged that reports were not submitted to the MCO within 72 hours.

Interview on 1/11/22 with the Director of Operations revealed:
-IRIS report was to be submitted by the Vice President of Operations.
-He was unaware as to why it was not in the system. He was guessing that the Vice President of Operations may not had clicked on the submit bottom at the end of the report.
-They had noticed it prior to surveyor visiting the

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V 367	Continued From page 6 center. He would follow-up and see what may had happened. -He conducted an internal investigation about what happened on 12/30/21 and how the girl got injured. -The girl had been consistent about how she got hurt during the restraint. -He believed there was no intent of abuse on behalf of the staff. Staff may had just done a bad restraint. -After the incident, he had a supervisory session with the staff. Discussed proper restraints. He asked staff to demonstrate to him that they knew how to make a restraint. In addition, all second shift staff received a restraining refresher training and they had to demonstrate that they knew the techniques to the instructor. Staff was also placed on a 90 days probation period. -He acknowledged that reports were not submitted to the MCO within 72 hours.	V 367		
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 clean, safe and attractive manner. The findings are:	V 736		

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V 736	Continued From page 7 Observation on 1/10/22 between 3:41 pm and 4:05 pm of the facility revealed: -Big Room/Activity Room- Edges of walls were dirty and had paint peeled off. -Wall in front of nurse's office- Repaired patch was not painted over/finished. -Door to conference room was dirty/stained. -Room #1- Unfinished repaired patches, they were not painted. There was a hole in the closet. Door frame had paint peeled off. -Room #2- Sheetrock was stripped off from on a wall and closet. -Room #3- Sheetrock was stripped off from on a wall and closet. -Room #4- Unfinished patch-up work not painted. There was Graffiti on a wall. -Bathroom A- Plastic cover on wall next to sink was broken on the edges. Unfinished patch-up work was not painted. Wooden door was not painted/stained. -Room #5- Sheetrock was stripped from wall by window and corner of the room. -Bathroom B- Very loud exhaust fan. Sheetrock was stripped from one of the walls. -Room #6- Unfinished patch-up work/ not painted. -Room #7- Unfinished patch-up work/not painted. Sheetrock was stripped off from a wall. -Room #8- There was Graffiti on closet. Air Conditioning vent on ceiling was bent forward and out of placement. -Room #9- Sheetrock was stripped off from walls. Interview on 1/10/22 with the Executive Director revealed: -She was aware that the facility needed to be repainted at certain places. -Indicated that the paint was being peeled off from the residents at the facility.	V 736		

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V 736	Continued From page 8 -She had put in work orders to repair things noted. -She had also put in orders for the facility to be repainted. -She confirmed the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		