STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL004-016	A. BUILDING: ______ B. WING ______	C 04/24/2024

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CORNERSTONE TREATMENT FACILITY	129 WALLCE ROAD WADESBORO, NC 28170

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on April 24, 2024. The complaints were substantiated (intake #NC00215448 and #NC00215686). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. The facility is licensed for 12 and currently has a census of 12. The survey sample consisted of audits of 5 current clients.	V 000		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a	V 314		

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community-based residential setting is essential to facilitate treatment.
(f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area.
(g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to coordinate client care with other individuals and agencies affecting one of five clients (#1). The findings are:

Review on 4/9/24 of client #1's record revealed:
-Admission date of 9/5/23.
-Diagnoses of Post Traumatic Stress Disorder Chronic; Attention Deficit Hyperactivity Disorder; and Predominantly Inattentive Type.
-15 years old.

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Review on 4/9/24 of a facility incident report dated 3/26/24 revealed:
-The RN observed client #1 run into the bathroom. "[Staff #6], [staff #7], and [RN] entered the bathroom where [client #1] was sitting on the floor crying saying to just leave [client #1] alone." [Staff #6], [staff #7], and [RN] processed with [client #1], [client #1] stood up and excited bathroom going out into residential hallway and trying to enter community area, but path was obstructed by [Executive Director]." "[Client #1] turned and entered into [client #1's] room, [staff #6], [staff #7], and [RN] again processed with [client #1] in efforts to clam her down, however, processing failed and client #1] tried pushing staff to gain access to residential hallway, for the safety of client, staff and peers, staff continued to block [client #1's] path causing her to become increasingly aggressive both physically and verbally." "[Staff #6 turned her back to exit room, [client #1] jumped from her bed to the back of [staff #6] and began pulling her hair, snatching out the hair from her scalp and hitting [staff #6]." "[Client #1] began to yell at [staff #6] you hurt me." [Client #1] said that [staff #6] choked [client #1] and triggered [client #1]." "[Staff #6] told [client #1] that [staff #6] did not hit or choke client #1.

Interview on 4/10/24 with the Department of Social Services's (DSS) Guardian for client #1 revealed:
-"[Qualified Professional (QP)] apologized to me for not telling me about the incident that happened with [client #1]."
-"[QP] was under the impression that the [Vice President of Operations] was supposed to call the guardian."
-"[QP] told me that the [Vice President of Operations] completes the incident reports and

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makes the calls to everyone involved."
-"I was notified by local County DSS yesterday (4/9/24) of the incident that they are currently investigating."
-"The [QP] sent me the incident report yesterday on 4/9/24."
-"I did a family and friends visit last week, and [client #1] nor the staff told me about the incident."

Interview on 4/18/24 with the QP revealed:
-"The guardian called me and told me that she was notified by local County DSS regarding the incident with [client #1]."
-Vice President of Operations notified the guardian when there are allegations.
-"[Vice President of Operations] notifies the local county Department of Social Services (DSS), the State, but not sure if Disability Rights, and Health Care Personnel Registry (HCPR) were notified."
-"I knew that the guardian wasn't notified when she called me to talk about the incident with [client #1]."
-"I apologized to the guardian for not notifying her about the incident and that was messed up."
-She assumed that the Vice President of Operation contacted the guardian when she completed the Incident Response Improvement System (IRIS) report online.
-"I would have notified the guardian if I would have known she wasn't notified."
-"The ball got dropped."

Interview on 4/9/24 with the Executive Director revealed:
-She remembered that an incident report was written, Child Protective Services (CPS) and DSS were notified of the incident.
-"I wasn't sure if HCPR or the guardian was notified."

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V 314	Continued From page 4 Interview on 4/15/24 with the Director of Operations revealed: -He was not aware that client #1's guardian wasn't notified of the incident. -"I thought [Vice President of Operations] had contacted the guardian after she completed the incident report in IRIS." -"Management has produced a form where it will show when guardian was notified and by whom."	V 314		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, one of five audited staff (#6) abused one of five current audited client (#1). The findings are:

Review on 4/9/24 of Staff #6's record revealed:
-Date of hire: 8/27/2018.

Review on 4/9//24 of client's #1 record revealed:
-Admission date of 9/5/23.
-Diagnoses of Post Traumatic Stress Disorder Chronic; Attention Deficit Hyperactivity Disorder; and Predominantly Inattentive Type.
-She was 15 years old.
-Assessment dated 9/8/23 had the following: "She (client #1) has a history of struggling with impulsively, lying, stealing, and not following rules. She is assaultive and has violent behavior towards peers and adults."

Review on 4/9/24 of a facility incident report dated 3/26/24 revealed:
-"[Registered Nurse (RN)] reported to hallway to observe [client #1] run into the bathroom. "[Staff #6], [staff #7] and [RN]entered into bathroom where [client #1] was sitting on floor crying saying to just leave her alone." "[Staff #6], [Staff #7], and [RN] processed with [client #1] telling [client #1] that she would have to exit bathroom but [client #1] refused staff directions." [RN], [staff #6], [staff #7] processed with [client #1], [client #1] stood up and exited bathroom going into residential hallway and trying to enter community area, but path was obstructed by staff." [Client #1] turned and entered into her room. [RN], [staff #6] and [staff #7] again processed with [client #1] in efforts to calm [client #1] down, however processing failed and [client #1] tried pushing

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staff to gain access to residential hallway, for the safety of [client #1], staff and peers staff continued to block [client #1] path causing her to become increasingly aggressive both physically and verbally. [Client #1's] bedroom door was closed to prevent [client #1] from running out of her room into hallway. [Client #1] began swinging and hitting staff to exit her room was not able to bypass staff. After approximately 20 minutes it had seemed that [client #1] was entering De-escalation. As [staff #6] turned her back to exit room, [client #1] jumped from her bed to the back of [staff #6] and began pulling [staff #6] hair, snatching out the hair from [staff #6] scalp and hitting [staff #6]. [Client #1] began to yell at [staff #6] you hurt me. You choked me and triggered me. [Staff #6] told [client #1] that [staff #6] did not hit or choke [client #1]. [Staff #6] exited [client #1's] room leaving [RN] and [staff #7] in room with [client #1]. [Client #1] became very emotional crying to [RN] and [staff #7] saying 'I am sorry but when [staff #6] choked [client #1] it triggered me because she hurt me.' [RN] informed [client #1] that [RN] did not see [staff #6] choke or hit [client #1] but incident would be reported to Executive Director/Administrator including RN's statement in incident report. No injuries visualized by [RN]. No medical intervention needed at this time."

Interviews regarding the 3/26/24 incident with client #1:

Interview on 4/9/24 with client #4 revealed:
-"I didn't see it but I heard the whole thing because I was in the room next door."
-"It was a lot of bumping in the room and very chaotic."
-"[Staff #6] was coming out the room with [staff #6's] shirt was halfway up showing her stomach."
-All the other clients were down the hall.

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Interview on 4/15/24 and 4/23/24 with staff #7 revealed:
-"[Staff #6] and [RN] called me because [client #1] would not come out of the bathroom."
-"When I had gotten to the bathroom, [RN] and [staff #6] were in the bathroom trying to calm [client #1] down."
-Client #1 refused to leave the bathroom.
-"Me and [staff #6] did a CPI restraint (Crisis Prevention Institute) to get [client #1] out the bathroom."
-"We were on both sides of [client #1] with our hands over [client #1's] fist so she wouldn't swing and held [client #1's] arms by her side."
-"Once we got [client #1] out the bathroom, we let her go."
-Client #1 ran into client #4's bedroom.
-"Me and [staff #6] were trying to calm [client #1] down so she could leave [client #4's] bedroom, but she refused."
-"Me and [Staff #6] did another CPI restraint the same way to get [client #1] out [client #4's] bedroom and took [client #1] to her bedroom."
-"Once we got to [client #1's] bedroom, I let her arm go because the three of us couldn't fit through the door."
-"Once [client #1] was in the room, [staff #6] pushed [client #1] up against the wall with her forearm up against [client #1's] neck."
-Client #1 and staff #6 fell on the bed.
-"I saw [client #1] grip [staff #6's] shirt while they were on the bed."
-"[Staff #8] and I tried to stop [client #1] from ripping [staff #6's] shirt."
-"We had gotten [client #1's] hands loose from gripping [staff #6's] shirt and [staff #6] had gotten up from the bed."
-"[Client #1] jumped up and punched [staff #6] in the back of her head."

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-"After [client #1] punched [staff #6], they both started fighting each other."
-"[Client #1] and [staff #6] were punching each other."
-Staff #8 and I broke up the fight between client #1 and staff #6.
-The RN had come back into the bedroom to escort staff #6 out of the bedroom.
-After the RN escorted staff #6 out of the room, the RN come back to check on client #1.
-"I don't know if they told management about the incident."
-"I don't remember if I told [Executive Director] about [client #1] and [staff #6] fighting each other."
-Management hasn't done any new training since the incident happened.

Interview on 4/11/24 and 4/23/24 with staff #8 revealed:
-"I was just getting back from getting something to eat and [client #1] was yelling get off me in [client #4's] bedroom."
-"[Staff #6] was holding [client #1] from the back in a bear hug."
-Staff #6 and staff #7 took client #1 out of client #4's bedroom to client #1's bedroom.
-"[Staff #7] was holding [client #1's] feet while [staff #6] had [client #1's] upper body."
-Client #1 was kicking and screaming while being taken to her bedroom.
-"[Staff #6] was still holding [client #1] from the back while standing by the window when I walked in the bedroom."
-"I heard [client #1] say that [staff #6] is the only staff that restrain them like that."
-"[Staff #6] was telling [client #1] that she can't fight anyways."
-Staff #6 had let client #1 go and client #1 sat on the bed.

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-"[Client #1] was sitting on the bed, jumped up and started punching [staff #6]."
-"[Staff #6] started hitting [client #1] and at that point they both were punching and fighting each other."
-They both fell on the bed.
-Client #1 was lying face up on her back and staff #6 was face forward on top of client #1.
-"I did see [staff #6] grab [client #1] by her neck, but I wasn't sure if [staff #6] was choking [client #1]."
-"[Client #1] had got angry and grab [staff #6's] hair and then [staff #6] grab [client #1's] hair."
-"I was trying to break them up by grabbing [client #1] and [staff #7] was grabbing [staff #6]."
-"It was loud and chaotic in the room."
-She fell trying to break up client #1 and staff #6 from fighting.
-"[Client #1] and [staff #6] pulled each other's hair out."
-"Once they both were broken up [staff #6] was still talking junk to [client #1] and [client #1] was still trying to fight [staff #6]."
-Staff #6 was the team lead that day and staff #6 was supposed to report all incidents to management.
-"I wasn't sure if [staff #6] was going to tell the truth about it."
-"I actually told [Executive Director] that [client #1] and [staff #6] were fighting each other after everything had calm down."
-"Management hasn't done any new training since the incident happened."

Interview on 4/9/24 and 4/23/24 with the RN revealed:
-She was in the nurse's office and heard a commotion down the hall around 5:00 -5:30pm.
-"By the time I got down the hallway [client #1] was in the bathroom with [staff #6]."

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V 512	Continued From page 10 -"Me and [staff #6] were coaching [client #1] and telling her to get up." -"I reached my hand down toward [client #1] to help get her up off the floor." -Client #1 had gotten off the floor and started walking out of the bathroom. -"I was walking side by side with [client #1] down the hallway and [client #1] just darted off." -Client #1 was trying to get into the community area. -Staff stepped in front of client #1 to keep her from running through the double doors. -"The staff never made contact with [client #1], but I can't remember which staff it was." -Client #1 had ran off into her bedroom. -She followed client #1 to her bedroom. -Staff #6, staff #7, and staff #8 were in the bedroom. -"We were all talking to [client #1] and trying to calm [client #1] down." -"At one point [client #1] was calming down and then [client #1] started digging at her skin." -Client #1 had gotten on her bed, laying sideways with her head towards the floor. -"[Client #1] was digging in her arms." -"I walked up toward [client #1's] face saying 'what's wrong' and 'what's going on with you'?" -"[Client #1] told me that everyone was p*****g her off." -Client #1 started calming down again. -"[Staff #6] turned to walk out the door and [client #1] jumped off the bed onto [staff #6's] back." -"[Client #1] wrapped her hand around [staff #6's] hair and pulled out dreadlocks from [staff #6's] scalp." -"I said 'oh wow' and told [client #1] 'stop'." -Client #1 pulled staff #6 on the bed while still holding staff #6's hair. -"I told [client #1] 'why you are attacking staff' and 'let her (staff #6) go'."	V 512		

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V 512	Continued From page 11 -"I saw [staff #6] grab [client #1's] hands to get [client #1's] hands out of [staff #6's] hair." -"[Staff #7] was helping [staff #6] get [client #1's] hand out of [staff #6's] hair." -"When [staff #6] got free [staff #6] walked straight out the door." -"I asked [client #1] why did you attack staff?" -"[Client #1] said that 'B***h choked' me." -"I immediately assess [client #1] when [client #1] said that [staff #6] choked her." -"I looked at [client #1] and did not see any scratches, redness, and no marks." -She didn't hear client #1 cough and client #1 was still yelling and talking. -"[Staff #7] was in the mix, and I wasn't able to see everything." -"I never seen [staff #6] choke [client #1]." -After the incident was over client #1 was upset and started crying. -Staff #6 also started crying after the incident. -"I checked on [client #1] throughout the remainder of the evening." -The incident started at 5:30pm and it was over at 6:00pm. -"The whole incident only lasted about thirty minutes." -"I worked until 12:00am and I'm not sure if [staff #6] finish the shift or not that night." -"I sent the incident report and my written statement to [Director of Operations], [Therapist], [Executive Director], and [QP]." -"It was sent from my personal email address because I don't have a company email address." -"I sent the email and incident report immediately because of everything that was going on." -"I did an incident report immediately due to the nature of the incident and faxed to upper management." -"There hasn't been any new training since the incident occurred."	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL004-016	A. BUILDING: ______ B. WING ______	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE TREATMENT FACILITY	129 WALLCE ROAD WADESBORO, NC 28170

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Interview on 4/12/24 with staff #6 revealed:
-"She was called to come down the hall because [client #1] was having a behavior."
-"When I had gotten down the hall, [client #1] was in bathroom B."
- I was telling client #1 that she couldn't be in here.
-"[RN] came into the bathroom and said the same thing I said to [client #1]."
-"[Client #1] left the bathroom and took off running toward the double doors where [staff #7] was standing."
-Staff #7 was talking to client #1 and was trying to get her to calm down.
-Client #1 had run into client #4's bedroom.
-"[Staff #7] dragged [client #1] from [client #4's] room to [client #1's] room by a bear hug from the back."
-Staff #7 was still trying to calm client #1 down.
-Staff #7 was moving stuff off the floor so nobody would fall and get hurt.
-"I saw [staff #7] push [client #1] onto the bed."
-"I turned around to leave the room because I thought [client #1] was done."
-"I felt someone jump on my back pulling me down to the floor by my hair."
-"At first, I thought it was [staff #7] because she was moving stuff off the floor to prevent everyone from falling. Once I realized it was [client #1] on my back pulling my hair."
-"[Client #1] had wrapped her hand around my hair trying to pull my hair out."
-"I was trying to get [client #1] to stop pulling my hair and still trying to talk to [client #1] to calm her down."
-"[Staff #8] helped me get [client #1's] hands out my hair."
-"[Client #1] said that I choked her, and I did not choke [client #1]."

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-"I had no reason to choke a child that I care about so much."
"I had not laid one hand on no child at the facility."
"I did not hit, kick, or pull [client #1's] hair while I was in the room."
-"I was suspended from the facility and now I have resigned."

Interview on 4/9/24 with Staff #9 revealed:
-"I was told by [client #1] that a staff had choked [client #1] in her bedroom."
-"I don't know what staff it was, and I don't remember the date it happened."
-"I reported the incident to the [Therapist] immediately."

Interview on 4/9/24 with the Therapist revealed:
-"[Staff #9] called me on my home phone to alert me about a confrontation between [client #1] and [staff #6]."
-"I called the acting [[Executive Director] and the current [Executive Director]] directly to let them know that an incident occurred, and they needed to get staff off the floor."
-He remembered notifying them about the incident on March 27, 2024.
-"[Client #1] told me that she was being non-compliant and two staff escorted [client #1] to her room."
-While in the room staff #7 had client #1 in a restraint and then staff #6 came over to assist staff #7.
-"[Client #1] told me that [staff #6] put her hands around her neck and that is when [client #1] hit [staff #6]."
-"[Client #1] told me that once [client #1] hit [staff #6], that is when they begin fighting each other."
-Management took staff #6 off the floor once the incident was reported.
-There hasn't been any new training since the

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incident happened.

Interview on 4/9/24 and 4/23/24 with the Executive Director revealed:
-"[Staff #9] was talking with [client #1] and [client #1] told staff #9 that [staff #6] choked her."
-"[Staff #9] reported the incident to [Therapist]."
-"[Therapist] reported the incident to the acting [Executive Director]."
-"Acting [Executive Director] reported the incident to me and [Director of Operations]."
-"[Director of Operations] reported the incident to [Vice President of Operations] who reported it to DSS."
-"[Client #1] did not tell the staff until a couple of days later."
-Staff #6 was taken off the schedule immediately and is currently on suspension until the investigation is completed.
-"None of the staff told me about the incident the day it happen."
-"[Staff #6] told me that [client #1] was fighting her and that was it."
-"[RN], [staff #7], nor [staff #8] did not say anything to me about [staff #6] fighting [client #1]."
-"I was informed of the incident the next day and that is when I spoke with all the staff that were in the room."
-"[Staff #6] finished out her shift at 12:00am and I stayed until 12am as well."
-The night of the incident was the last day staff #6 worked.
-There hasn't been any new training after the incident occurred.

Interview on 4/9/24 with the Director of Operations revealed:
-Client #1 told him that staff #6 choked her.
-"[Client #1] said that [staff #6] pushed her up

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against the wall with [staff #6's] forearm up against [client #1's] neck in her bedroom."
-"[Client #1] told me that [staff #6] threw [client #1] on the bed and choked her."
-Client #1 had gotten upset and jumped on staff #6.
-"The incident started with [client #1] wanting to pace the hallway and staff refused to let [client #1] pace the hallway."
-"[Staff #6] told me that [client #1] had [staff #6's] hair from the front and was pulling it down."
-"[Staff #6] said that she couldn't see and didn't know what was going on."
-"[Staff #6] told me that she did not choke [client #1] or throw [client #1] on the bed."
-The staff were blocking client #1 from coming up the hallway to keep client #1 from attacking the other clients.
-The incident was told to staff #9 by client #1 when they both were having a regular conversation.
-"[Staff #9] reported the incident to [Therapist]."
-"[Therapist] reported the incident to acting [Executive Director] at the time."
-"Acting [Executive Director] notified [Vice President of Operations] and me about the incident."
-"[Staff #6] was taken off the schedule immediately and is currently on suspension."
-"We haven't done any new training since the incident occurred."

Review on 4/24/24 of a Plan of Protection written by the Executive Director dated 4/24/24 revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will conduct bi-weekly trainings to ensure staff is knowledgeable of proper

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monitoring. Use of appropriate cadence, tone, and volume and effective de-escalation techniques. Staff will notify the Executive Director of any incidents rather they are physical or verbal to comply with proper use of the chain of command.
Describe your plans to make sure the above happens. Senior Team Leader, Team Leaders, and Leaders will debrief per shift. The Executive Director will review incident reports and daily behavior log to ensure compliance. Supervisors will be conducted with those personnel who do not comply with facility expectations. Verbal warning, write ups and supervision will be conducted. If staff are not in compliance termination will be recommended."

Client #1 was a 15 year old diagnosed with PTSD Chronic and ADHD Predominantly Inattentive Type. An incident occurred on 3/26/24 with client #1 and staff #6 while client #1 was having a behavior of yelling and throwing things. During client #1's behavior episode she hit staff #6 who in turn started hitting client #1. Staff #6 and client #1 were punching and fighting each other. At one point client #1 was face up on the bed with staff #6 on top of her. Staff #6 and client #1 were also pulled each other's hair during this fight. Staff #7 and staff #8 had to break up the fight and separated staff #6 from client #1.

This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.