STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED					
		A. BOILDING.						
		MHL004-016	B. WING		C 06/21/2024			
NAME OF D	DOVIDED OD SLIDDLIED	STDEET A	DDBESS CITY STA	TE ZIR CODE				
NAME OF FI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 129 WALLCE ROAD							
CORNERS	STONE TREATMENT FAC	CILITY	BORO, NC 28170)				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
V 000	000 INITIAL COMMENTS		V 000					
	A complaint survey was completed on June 21, 2024. The complaint was substantiated (intake #NC00216650). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.							
	_	d for 12 and has a current vey sample consisted of ents.						
V 118	27G .0209 (C) Medica	ation Requirements	V 118					
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe							
	clients only when auth client's physician.	be self-administered by norized in writing by the						
	administered only by unlicensed persons tr pharmacist or other le privileged to prepare	ding injections, shall be licensed persons, or by ained by a registered nurse, agally qualified person and administer medications. inistration Record (MAR) of						
	all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name;	I to each client must be kept administered shall be after administration. The following:						
	(C) instructions for ad	nd quantity of the drug; ministering the drug; drug is administered; and						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I EAR OF CONNECTION		A. BUILDING:		COMPLETED		
		MHL004-016	B. WING		C 06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CORNERS	STONE TREATMENT FAC	CILITY 129 WALL	CE ROAD DRO, NC 28170	1		
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	T .	PROVIDER'S PLAN OF CORRECTION	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 1	V 118			
	(E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medication as ordered by a person authorized by law to prescribe drugs affecting 1 of 3 audited clients (#1). The findings are:					
	-Admission date of: 7 -Diagnoses of Disrup Disorder, Posttrauma Attention Deficit Hyperactivity I	tive Mood Dysregulation				
	order dated 7/21/23Propranolol (anxiety tablets by mouth daily	i client #1's signed physician) 20mg (milligrams) Give 2 y every morning. Give 2 y at 4:00 pm. Give 4 tablets ltime.				
	dated 4/19/24 reveale -"[Client #1] takes 2 F					

Division of Health Service Regulation

STATE FORM PKHK11 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		MHL004-016	B. WING		C 06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CORNERS	STONE TREATMENT FAC	CILITY 129 WALL	CE ROAD			
WADESBO			ORO, NC 28170)		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page 2		V 118			
V 118	Propranolol tablets at medications were given available her 2 tablets able to administer from a proximately 10:00 a were received from an and [Client#1's] Propropropropropropropropropropropropropr	es 8:00 pm. When 8:00 am en [Client #1] did not have so of Propranolol doses to be m pharmacy. At am the medications that m delivery were checked in ranolol refill had arrived, N)] placed 8:00 am dose of at #1] 4:00 pm dose of 2 daily does of 8 tablets." with client #1 revealed: when I went on an outing to the gave me the pills that g of pills and gives it to the mave five pills instead of ." It was too many blue pills, the re right." It was too many blue pills, the re right." It was too many blue pills, the re right. The this ever happened to me this ever happened to me this ever happened to me this ever happened to egot back to the facility that I bills."	V 118			
	-She received the medication right before [Client #1] had left to go out on the outing.					

Division of Health Service Regulation

STATE FORM 6899 PKHK11 If continuation sheet 3 of 7

Division of Health Service Regulation								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:				
MUI 004 04C		B. WING		C				
		MHL004-016			06/21/2024			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
	129 WALLCE ROAD							
CORNERS	STONE TREATMENT FAC	WADESE	ORO, NC 2817	0				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)			
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE			
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE			
				DEI IGIENCI)				
V 118	Continued From page	e 3	V 118					
	-"I had packaged a to	otal of 7 pills with the two						
	extra pills that [Client							
	morning."	_						
	- "If [Client #1] doesn	't get the correct dosage it						
	will trigger [Client #1]	into a psychotic episode."						
	-"[Client #1] will start	having anxiety which will						
	lead into uncontrollab							
		of eight pills of Propranolol						
	per day with two in th	•						
	afternoon, and four a							
		changes in [Client #1's]						
		[Client #1] because they						
	were already on the v							
		xtra dosage that was given						
	_ =	of the MAR, wrote an						
	incident report, and w	loctor that I had given [Client						
		e at 4:00 pm med pass." "I						
		otify the doctor to give an						
	extra dose at a different	•						
		a problem giving [Client #1]						
		pranolol because client #1						
	takes four pills at nigh							
		any ill effects from taking an						
	extra dose at 4:00 pm	·						
	-"[Client #1] and the [Executive Director] came to						
	see me after they got	back from the outing with						
	the concern of [Client medication."	t #1's] taking too much						
		hat she took too many pills						
		d pass while on the outing."						
		she was only supposed to						
	take five pills and too	• • •						
	· -	at #1] and the [Executive						
		extra pills were the pills						
	[Client #1] missed at	•						
		med pass the pills weren't						
	_	pharmacy running late."						
	-When the pills had g							
	packaged the pills up, and gave them to staff							

STATE FORM 6899 PKHK11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I EAN OF CONNECTION		A. BUILDING: _		COMPLETED		
		MHL004-016	B. WING		C 06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CORNERSTONE TREATMENT FACILITY 129 WALLCE ROAD						
OOMILIA	TONE INCAMENT IA	WADESB	ORO, NC 28170	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE	
V 118	Continued From page	e 4	V 118			
V 110	while they were on the "I told [Client #1] that the extra two pills in the "[Client #1] said 'okat questions." -"I think I told [Dr. Will Tuesday when we had idn't document it." Interview on 6/19/24 -When going on a lor package the client's indate, initials, and time	te van. It I didn't have time to explain the package." It's, and didn't have any other ison] about the incident on ad our weekly meeting but I with Staff #1 revealed: In gouting the nurse would medication in a bag with the	VIIIO			
	administered"[Administrative Assistant] told me to give [Client #1] and [Client #6] their medication at 4:00 pm." -"I don't remember how many pills were in the bag because the pills were already bagged up." -"I gave [Client #1] and [Client #2] a drink to take with their medications and watched them swallow the pills."					
	and did not have an imedication." -"[Client #1] was talkine took too many pillvan." -"Staff don't count the client what's in the banurse."	ing to [Staff #2], saying that is while on the back of the emedication, just give the ag that is prepared by the ing normal and didn't have king the medication."				
	revealed: -"When [Client #1] ha outing, [Client #1] told	with the Executive Director ad gotten back from the d me that there were seven ag, and it was only supposed				

Division of Health Service Regulation

STATE FORM PKHK11 If continuation sheet 5 of 7

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY					
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		7 BOILBING.						
				С				
MHL004-016		B. WING		06/21/2024				
					00/21/2021			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
129 WALLCE ROAD								
CORNERS	STONE TREATMENT FAC	CILITY						
		WADESE	BORO, NC 2817	J				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)			
PRÉFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE				
				DEFICIENCY)				
V 118	Continued From nego	· F	V 118					
V 110	Continued From page	÷ 5	V 110					
	to five pills in the zip I	ock had "						
		she took all seven pills that						
		•						
	were in the zip lock ba							
		vhy she took all seven pills						
	knowing [Client #1] w	as only supposed to take						
	five pills?"							
	-"[Client #1] told me tl	hat she took the pills						
	=	idn't want the [RN], to be						
	mad at her."	idirt want the [rtry], to be						
		ha madiantian in a min lank						
	-"The [RN] will pack the medication in a zip lock							
	bag with the client's initials and the time							
medication is supposed to be administered."								
	-Staff would have a bottle of water and watched the clients take their medication.							
	-"[Client #1] had come	e back from the outing						
	telling me that staff ga	_						
		ave her too much						
	medication."							
		[‡] 1] to the nurse to inquire						
	about the medication	[Client #1] had taken while						
	on the outing.							
	-"The [RN] explained	to [Client #1] that she						
		nedication due to being						
	delivered late."							
		Client #11 the IDNI						
	-"The [RN] informed [Client #1] the [RN] packaged an extra 2 pills to give to her at 4:00							
	1							
	pm to make sure [Client #1] doesn't miss any							
	medication."							
	-"[Client #1] understo	od everything the [RN] told						
	her about the medical	tion and had no ill effects."	1					
		he nurse notifying the doctor						
		n extra dosage at 4:00 pm						
	medication pass."	ii chiia dosaye at 4.00 piii						
	medication pass.							
	Interview on 6/21/24	with the Director of						
	Operations revealed:							
	-"I wasn't aware that I	[Client #1] had taken two			 			
	-	4:00 pm dosing while on an						
	outing in April 2024."							
		o [Evocutive Director] that	1					
	- i was later told by th	ne [Executive Director] that	1					

Division of Health Service Regulation

[Client #1] had taken two extra pills while on the

STATE FORM 6899 PKHK11 If continuation sheet 6 of 7

PRINTED: 06/26/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED			
		MHL004-016	B. WING		I	C / 21/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CORNERSTONE TREATMENT FACILITY 129 WALLCE ROAD WADESBORO, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
V 118	outing." -"The RN packages t medication is given to the medication to the -"I don't know anythir to being prepackaged -"I think the doctor wa Tuesday during their -"I will make sure the before giving any ext compliance."	ne client's medication, the o staff, and staff administers clients." In graph about the medication due of by the nurse." It is notified of the incident on weekly meeting. In nurse notifies Dr. Wilson or a pills to ensure In a note and incident report	V 118					

Division of Health Service Regulation

STATE FORM 6899 PKHK11 If continuation sheet 7 of 7