Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COWFLE	IED					
		MHL004-016	B. WING		02/07	//2025					
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE							
CORNERSTONE TREATMENT FACILITY WADESPORD, NO. 28170											
WADESBORO, NC 28170  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)											
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE					
V 000	INITIAL COMMENTS		V 000								
		up survey was completed A deficiency was cited.									
		d for the following service 27G .1900 Psychiatric It for Children and									
		d for 12 and has a current vey sample consisted of ents.									
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736								
		EMENTS									
	was not maintained in	as evidenced by: n and interviews, the facility n a safe, clean, attractive, tept free from offensive odor.									
	revealed: -Bedroom #1- The up were missing three pi -Room #2- The upper missing four pieces. F -Room #3- The upper missing three pieces. on the column conner -Room #4- Paint was	peeling on walls. ling on both sides on the									

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

TITLE (X6) DATE 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 SURVEY COMPLETED					
MHL004-016			B. WING		02	02/07/2025					
NAME OF P	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE										
CORNER	STONE TREATMENT FAC	CILITY	_CE ROAD ORO, 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	OULD BE COMPLETE					
V 736	-Room #6- Paint peel column connected to -Room #7- The upper missing four piecesRoom #9- Paint peel wall in red by the light -Paint was peeling on bedroom area.  Interview on 2/6/25 w revealed: -"The clients are teari -"Maintenance are stawhere the clients can to tear up the blinds." -"Maintenance came wall. They said that the walls next week"I did not realize that Interview on 2/7/25 w revealed: -"Maintenance molde the walls." -"The paint they had on the paint they had on the column are restant to the walls." -"The paint they had on the column are restant to the paint they had on the column are restant to the paint they had on the column are restant to the paint they had on the column are restant to the paint they had on the paint	ing on walls and left side of the closet. I left side of the blind were ing on walls. Writing on the switch. I both hallway walls in the lith the Senior Team Leader ong the blinds down." I arting to cover up the holes enter behind the plexiglass and putty all the holes in the ley will be back to paint the lith the Executive Director d and putted the holes on order the right color of paint in." I linds were missing.	V 736								

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