

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL004-016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/15/2026
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE TREATMENT FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 129 WALLCE ROAD WADESBORO, NC 28170
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on January 15, 2026. The complaints were unsubstantiated (intake #NC00234690 and NC00234849). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 12 and has a current census of 9. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 132	<p>G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY</p> <p>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:</p> <ol style="list-style-type: none"> a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. 	V 132		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 132	<p>Continued From page 1</p> <p>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of an allegation of abuse against the Former Staff. The findings are:</p> <p>Review on 1/8/26 of the facility's in-house incident report dated 8/5/25 revealed: -"On October 29, 2025 at approximately 5:40pm, a verbal altercation occurred between the client and staff. Staff involved removed themselves from the community area and were relocated to the administrative office area. The client attempted to break down the door between the client and the staff, but was unsuccessful. [Former Staff #2] reported that he blocked the door to prevent the [client #1] from entering the unauthorized area and that he then smashed his finger on the door. The [client #1] reported that [Staff #1] called her a b***h and [Former Staff #1] pushed her. [Staff #1] denied these allegations. No other injuries were reported to [RN]. [Client #1] denied any need for medical assistant. States she is fine. End of report."</p> <p>Review on 1/8/26 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no report submitted for the allegation</p>	V 132		

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V 132	<p>Continued From page 2</p> <p>by Client #1, that [Former Staff #1] was physically abusive.</p> <p>Interview on 1/8/26, 1/9/26, and 1/13/26 with the House Manager revealed: -"I didn't complete the incident report, and I did not notify (HCPR)." -"I am not responsible for notifying HCPR or completing the IRIS report." -"Management had dropped the ball."</p> <p>Interview on 1/9/26 and 1/14/26 with the Qualified Professional (QP) revealed: -"I didn't do the IRIS report of the incident that happened on October 29, 2025." -"The HCPR wasn't notified because the IRIS report was completed."</p> <p>Interview on 1/14/26 with the Director of Operations revealed: -"I was not aware of the allegations that were made against [FS #1] pushing [client #1] until recently." -"I told management at the facility that if anything happens whether it's small or large I need to know." -"If I had known about the allegation I would have reported to entities involved myself." -"Management at the facility had dropped the ball." -He confirmed the agency failed to report allegations of abuse to HCPR.</p>	V 132		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and</p>	V 366		

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V 366	<p>Continued From page 3</p> <p>implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p>	V 366		

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V 366	<p>Continued From page 4</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to</p>	V 366		

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V 366	<p>Continued From page 5</p> <p>Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement a policy governing their response to Level II and Level III incidents as required. The findings are:</p> <p>Review on 1/8/26 of the facility's in-house incident report dated 8/5/25 revealed: -"On October 29, 2025 at approximately 5:40pm, a verbal altercation occurred between the client and staff. Staff involved removed themselves from the community area and were relocated to the administrative office area. The client attempted to break down the door between the client and the staff, but was unsuccessful. [Former Staff #2] reported that he blocked the door to prevent the [client #1] from entering the unauthorized area and that he then smashed his finger on the door. The [client #1] reported that [Staff #1] called her a b***h and [Former Staff #1] pushed her. [Staff #1] denied these allegations. No other injuries were reported to [RN]. [Client</p>	V 366		

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V 366	<p>Continued From page 6</p> <p>#1] denied any need for medical assistant. States she is fine. End of report."</p> <p>Review on 1/8/26 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> -There was no report submitted for the allegation by [Client #1], that [Former Staff #1] was physically abusive. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. <p>Interview on 1/8/26, 1/9/26, and 1/13/26 with the House Manager revealed:</p> <ul style="list-style-type: none"> -"I didn't complete the incident report, and I didn't do the IRIS report." -"I am not responsible for completing the IRIS report." -"I thought when [client #1] recanted her story that we didn't have to do the IRIS report." <p>Interview on 1/9/26 and 1/14/26 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -"I didn't do the IRIS report of the incident that happened on October 29, 2025." -"The IRIS report was not completed by the [Administrative Assistant] because she wasn't emailed the incident." -"Management had dropped the ball." <p>Interview on 1/14/26 with the Director of Operations revealed:</p> <ul style="list-style-type: none"> -"I was not aware of the allegations that were 	V 366		

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V 366	Continued From page 7 made against [FS #1] pushing [client #1] until recently." -If I had known about the allegation I would have reported to entities involved myself." -"Management at the facility had dropped the ball." -He confirmed the facility failed to implement a policy governing their response to Level II and Level III incidents as required.	V 366		
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; (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.	V 367		

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V 367	<p>Continued From page 8</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p>	V 367		

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V 367	<p>Continued From page 9</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident was reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:</p> <p>Based on record review and interviews, the facility failed to implement a policy governing their response to Level II and Level III incidents as required. The findings are: Review on 1/8/26 of the facility's in-house incident report dated 8/5/25 revealed: -"On October 29, 2025 at approximately 5:40pm, a verbal altercation occurred between the client and staff. Staff involved removed themselves from the community area and were relocated to the administrative office area. The client</p>	V 367		

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V 367	<p>Continued From page 10</p> <p>attempted to break down the door between the client and the staff, but was unsuccessful. [Former Staff #2] reported that he blocked the door to prevent the [client #1] from entering the unauthorized area and that he then smashed his finger on the door. The [client #1] reported that [Staff #1] called her a b***h and [Former Staff #1] pushed her. [Staff #1] denied these allegations. No other injuries were reported to [RN]. [Client #1] denied any need for medical assistant. States she is fine. End of report."</p> <p>Review on 1/8/26 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> -There was no report submitted for the allegation by [Client #1], that [Former Staff #1] was physically abusive. Interview on 1/8/26, 1/9/26, and 1/13/26 with the House Manager revealed: <ul style="list-style-type: none"> -"I didn't complete the incident report, and I didn't do the IRIS report." -"I am not responsible for completing the IRIS report." -"I thought when [client #1] recanted her story that we didn't have to do the IRIS report." Interview on 1/9/26 and 1/14/26 with the Qualified Professional (QP) revealed: <ul style="list-style-type: none"> -"I didn't do the IRIS report of the incident that happened on October 29, 2025." -"The IRIS report was not completed by the [Administrative Assistant] because she wasn't emailed the incident." -"Management had dropped the ball." Interview on 1/14/26 with the Director of Operations revealed: <ul style="list-style-type: none"> -"I was not aware of the allegations that were made against [FS #1] pushing [client #1] until 	V 367		

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V 367	Continued From page 11 recently." -If I had known about the allegation I would have reported to entities involved myself." -"Management at the facility had dropped the ball." -He confirmed the facility failed to report the above incidents to LME/MCO within 72 hours.	V 367		