AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED
		mhi049-098	B. WING		07/20/2018
NAME OF D	DOVIDED OD SUIDDUED	OTDEET AD	DDEEC CITY OF	TATE ZID CODE	1
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	
STICKNE	Y HOUSE		(WELL LOOP VILLE, NC 281	115	
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPEDEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 7/20/18. Two comp	Superior to refer to the recognition of the control		i	
	category: 10A NCAC			DHSR - Mental He	alth
	Treatment Staff Secure for Children or Adolescents.			AUG 082018	
V 536	27E .0107 Client Righ Int.	ts - Training on Alt to Rest.	V 536	Lic. & Cert. Section	on
	to restrictive interventi (b) Prior to providing s disabilities, staff include employees, students of demonstrate competer completing training in other strategies for cre which the likelihood of or injury to a person w property damage is pre (c) Provider agencies based on state compete compliance and demongathered. (d) The training shall b include measurable lea measurable testing (wi	element policies and ize the use of alternatives ons. services to people with ding service providers, or volunteers, shall noce by successfully communication skills and eating an environment in imminent danger of abuse ith disabilities or others or evented. shall establish training tencies, monitor for internal instrate they acted on data are competency-based, arning objectives, ritten and by observation of ectives and measurable			

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

TITLE

(X6) DATE

FP0811

PRINTED: 07/23/2018 FORM APPROVED

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	8
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
STICKNEY HOUSE 120 ROCKWELL LOOP	
MOORESVILLE, NC 28115	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	X5) IPLETE ATE
V 536 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) Knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the persons involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include. (A) who participated in the training and the outcomes (pass/fail);	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 536 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	07/20/2018		A. BOILDING.			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 ROCKWELL LOOP MOORESVILLE, NC 28115 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 2 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	07/20/2018					
STICKNEY HOUSE Comparison of the properties of the provided state of the provided sta			B. WING	mhl049-098		
X(4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 2 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.		ATE, ZIP CODE	DRESS, CITY, ST	STREET AD	PROVIDER OR SUPPLIER	NAME OF F
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 2 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.		15			Y HOUSE	STICKNE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 2 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	TION (X5)		1		SUMMARY ST	(VA) ID
(B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	ULD BE COMPLETE	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
(C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.			V 536	2	Continued From page	V 536
by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions, reducing and eliminating the need for restrictive interventions at least once			V 536	where they attended; and name; not MH/DD/SAS may ocumentation at any time. Actions and Training all demonstrate competence desting in a training program reducing and eliminating the deriventions. All demonstrate competence grade on testing in an argam. Shall be include measurable learning the detection of the instructor training the stock of the instructor training the stock of the instructor training the stock of this Rule. Instructor training programs of limited to presentation of the adult learner; teaching content of the evaluating trainee on procedures. All have coached experience on gram aimed at preventing, not the need for restrictive one time, with positive all teach a training program deducing and eliminating the	(B) when and w (C) instructor's (2) The Division review/request this do (i) Instructor Qualificate Requirements: (1) Trainers shat by scoring 100% on the aimed at preventing, red need for restrictive into (2) Trainers shat by scoring a passing of instructor training proof (3) The training competency-based, in objectives, measurable observation of behavior measurable methods failing the course. (4) The content service provider plans approved by the Divist to Subparagraph (i)(5) (5) Acceptable is shall include but are not (A) understandir (B) methods for course; (C) methods for course; (C) methods for performance; and (D) documentation (6) Trainers shat teaching a training proof reducing and elimination interventions at least of review by the coach. (7) Trainers shat aimed at preventing, reducing,	V 536

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
		mhl049-098	B. WING		07/:	20/2018
STICKNEY HOUSE 120 ROC		DDRESS, CITY, STAT KWELL LOOP VILLE, NC 2811				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	annually. (8) Trainers shainstructor training at legity Service providers and documentation of initiateraining for at least three (1) Docume (A) who participate outcomes (pass/fail); (B) when and with (C) instructor's in (2) The Division request and review this (k) Qualifications of Concess share equirements as a trainer (2) Coaches share equirements as a trainer (3) Coaches share course which is began to competence by complete and the trainer instruction of the course which is as for trainers. This Rule is not met as Based on record review facility failed to ensure alternatives to restriction.	all complete a refresher east every two years. shall maintain al and refresher instructor ee years. Intation shall include: ated in the training and the here attended; and name. of MH/DD/SAS may is documentation any time. In oaches: all meet all preparation in er. all teach at least three times being coached. all demonstrate ection of coaching or ection. all be the same preparation is sevidenced by: with a same in the same preparation in training on we interventions was	V 536			
	completed annually affecting 1 of 3 surveyed staff (staff #1). The findings are: Review on 7/19/18 of staff #1's record revealed: -a hire date of 7/10/17; -documentation that training on alternatives to restrictive interventions was completed on					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		mhl049-098	B. WING		07/2	20/2018
NAME OF P	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
STICKNE	Y HOUSE		WELL LOOP ILLE, NC 281	115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	6/29/17; -no documentation that completed since 6/29/ Interview on 7/19/18 w Professional revealed: -she had been certified alternatives to restrictive weeks ago; -she had not had time all the staff yet; -staff #1 had not compyet; -she planned to sched	at the training had been /17. with the Qualified l: d to instruct the training on ive interventions about 3 e to complete the training for colleted the refresher training dule a training within the	V 536	- New trainer certified - Re-cert class scheduld is - Two mindset trainings all employees, 2 day in followed by 2 week in- training. re-cert cla week training	8,23,18 for atro depth	8,23,18 9,3,18
	next couple of weeks. 27E .0108 Client Right ITO 10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OUT (a) Seclusion, physicatime-out may be employeen trained and have competence in the proto these procedures. If staff authorized to emprocedures are retrained competence at least at (b) Prior to providing disabilities whose treat includes restrictive intereservice providers, emprovolunteers shall compleseclusion, physical res	TRAINING IN CAL RESTRAINT AND IT all restraint and isolation oyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that ploy and terminate these led and have demonstrated innually. direct care to people with tement/habilitation plan erventions, staff including ployees, students or lete training in the use of straint and isolation time-out e interventions until the	V 537	*Trainer is owner Josh Beesle		

Division of Health Service Regulation

STATE FORM

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				31000000000000000000000000000000000000	
			B. WNG		
	16.1	mhl049-098] D. VIII.10		07/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	
		120 ROCK	WELL LOOP		
STICKNE	Y HOUSE	MOORESV	ILLE, NC 281	115	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (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 APPROPE	RIATE DATE
				DEFICIENCY)	
V 537	Continued From page	5	V 537		
(0.0000000					
		r taking this training is			
		etence by completion of			
		reducing and eliminating			
	the need for restrictive				
		be competency-based,			
	include measurable le	• ,			
		vritten and by observation of			
		ejectives and measurable			
		passing or failing the			
	course.	torining according a constitute of			
		training must be completed			
		der periodically (minimum			
	annually).	ning that the convice			
	(f) Content of the trai	loy must be approved by			
	the Division of MH/DE				
	Paragraph (g) of this	ā .			
		ng programs shall include,			
	but are not limited to,				
		formation on alternatives to			
	the use of restrictive in				
		n when to intervene			
		ent danger to self and			
	others);	3			
		n safety and respect for the			
		Il persons involved (using			
		rictive interventions and			
	incremental steps in a	n intervention);			
	(4) strategies fo	r the safe implementation			
	of restrictive interventi	ons;			
	(5) the use of er	mergency safety			
	interventions which in	clude continuous			
	assessment and moni	toring of the physical and			
		ng of the client and the safe			
	use of restraint throug	hout the duration of the		5	
	restrictive intervention	;			
	(6) prohibited pr	ocedures;			
		rategies, including their			
	importance and purpo	se; and			

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		mhl049-098	B. WING		07/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	
STICKNE	V HOUSE	120 ROCK	WELL LOOP		
STICKNE	I HOUSE	MOORESV	ILLE, NC 281	15	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 537	Continued From page	6	V 537		
V 537	(8) documentate (h) Service providers documentation of initia at least three years. (1) Documentate (A) who participa outcomes (pass/fail); (B) when and we (C) instructor's (2) The Division review/request this documents: (1) Trainers share by scoring 100% on the aimed at preventing, received for restrictive interest (2) Trainers share by scoring 100% on the teaching the use of seand isolation time-out. (3) Trainers share by scoring a passing of instructor training proof (4) The training competency-based, in objectives, measurable methods of failing the course. (5) The content service provider plans approved by the Divisit to Subparagraph (j)(6) (6) Acceptable i shall include, but not be of: (A) understanding the course of the content service includes the course of the course	ion methods/procedures. shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may recumentation at any time. ation and Training all demonstrate competence resting in a training program reducing and eliminating the rerventions. In demonstrate competence resting in a training program reclusion, physical restraint all demonstrate competence resting in a training program reclusion, physical restraint all demonstrate competence resting in an an an an arran. In the state of the state of the instructor training the reclude measurable learning reclude measurable r	V 537		
		teaching content of the			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
7110 1 27111	or connection	DENTI TO ATTOCK TO MIDER.	A. BUILDING:	T 218 W. W. I		
		mhl049-098	B. WING		07/2	20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
STICKNE	Y HOUSE	120 ROCK	WELL LOOP			
		MOORESV	ILLE, NC 281	15		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	(D) documentati (7) Trainers sha annually and demons of seclusion, physical time-out, as specified Rule. (8) Trainers sha CPR. (9) Trainers sha in teaching the use of least two times with a coach. (10) Trainers sha use of restrictive intervanually. (11) Trainers sha instructor training at le (k) Service providers documentation of initial training for at least thr (1) Documentat (A) who participal outcome (pass/fail); (B) when and w (C) instructor's in (2) The Division review/request this do (I) Qualifications of Co (1) Coaches sha requirements as a trail (2) Coaches sha times, the course which	of trainee performance; and on procedures. All be retrained at least trate competence in the use restraint and isolation in Paragraph (a) of this all be currently trained in all have coached experience restrictive interventions at positive review by the all teach a program on the ventions at least once and refresher east every two years. Shall maintain all and refresher instructor ee years. In it is include: All the training and the shere they attended; and name. If MH/DD/SAS may cumentation at any time. Daches: All meet all preparation neer. All teach at least three the is being coached. All demonstrate etion of coaching or cition. The shell be the same	V 537			

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WNG mhl049-098 07/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 ROCKWELL LOOP STICKNEY HOUSE MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 537 V 537 Continued From page 8 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff received training in - Goal to have all employees seclusion, physical restraint and isolation time out expiring in 2018 re-certified by 9.30,18 prior to providing services to clients, affecting 1 of 3 surveyed staff (the Licensed Professional/Clinical Director (LP/CD)) and failed to ensure staff were retrained at least annually, - New training procedure: neek affecting 1 of 3 surveyed staff (staff #1). The in-depth mindset for all employees; findings are: 11.20.18 quarterly "refreshe" classes stating Review on 7/19/18 of staff #1's record revealed: -a hire date of 7/10/17; Operations Myr Dune responsible -documentation that training on alternatives to restrictive interventions was completed on 6/29/17: -no documentation that the training had been completed since 6/29/17. Review on 7/19/2018 of the LP/CD's employee file revealed: -a hire date of 3/19/18; -no documentation of training in seclusion, physical restraint and isolation time out. - LP/CD received training and is fully certified Interview on 7/19/18 with the LP/CD revealed: 7.26.18 -she had not received training in seclusion, physical restraint and isolation time out; -she thought she was exempt from the training. Interview on 7/19/18 with the Qualified

Division of Health Service Regulation

Professional revealed:

about 3 weeks ago;

-she had been certified to instruct the training in seclusion, physical restraint and isolation time out

-she had not had time to complete the training for

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		mhl049-098	B. WING		07/20/2018
NAME OF PI	PROVIDER OR SUPPLIER Y HOUSE	120 ROCK	DRESS, CITY, STA KWELL LOOP VILLE, NC 281		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 537	all the staff yet; -she thought the LP/C training with the previoshe verified with the I completed the training	CD had completed the ous instructor; LP/CD that she had not g; dule a training within the	V 537		
V 736	10A NCAC 27G .0303 EXTERIOR REQUIRE (c) Each facility and its maintained in a safe, of manner and shall be k odor.	EMENTS s grounds shall be clean, attractive and orderly kept free from offensive	V 736	-All Kitchen cabinets to be	a in IA
	failed to maintain the fattractive manner. The attractive manner. The Observations from app pm on 7/19/18 of the fattractive was damage to drawer beside the dish the drawer contained smaterial; -the handle of the refrighthe front of the bottom missing; -the bottom shelf in the the wall; -the bottom of the left w#1 was not attached;	s and interviews, the staff facility in a safe, clean and a findings are: proximately 2:34 pm - 3:00 facility revealed: the outside of a small hwasher and the inside of small pieces of wood like digerator was missing; in drawer in the kitchen was be pantry hung loosely from window screen in bedroom overs in bedrooms #1, #2,		-All Kitchen cabinets to be replaced by 9/10 (Dranes too) -Fridge door handledered, installed -Pantry shelf fix Ethinge door in -Window screen V and fix Ethinge - Light covers ordered, install -	

FPO811

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WNG mhl049-098 07/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 ROCKWELL LOOP STICKNEY HOUSE MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 Continued From page 10 V 736 Regarding wall smudges, facility interior to be painted entirely -there were numerous stains on the wall in bedroom #1 and the living room. 8.17.18 Interview on 7/19/18 with the Associate Professional revealed: -Environmental Health had inspected the facility the previous week and the facility was issued a provisional license due to lots of things that needed to be repaired or cleaned; -she was glad that the inspection had been completed: -she had concerns about the condition of the facility such as repairs that needed to be made and the lack of cleanliness that was now being addressed; -staff had cleaned and repaired as much as they could during the past week but she was aware there were still things that needed to be repaired; -there were 2 new light covers in the office that needed to be put up in the facility but she was waiting on someone to come and put them up because there was not a ladder at the facility for -the Owner informed her that he was not going to repair the drawers that had damage in the kitchen because it wasn't financially feasible and she wasn't sure about the refrigerator but the other repairs were going to be completed within the next couple of weeks. Interview on 7/19/18 with the Licensed Professional/Clinical Director revealed: -she had concerns about the condition of the facility regarding repairs that needed to be made and the lack of cleanliness; -Environmental Health had inspected the facility the previous week and since that time, her

Division of Health Service Regulation

concerns had been addressed;

needed to be completed.

-she was aware there were further repairs that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		mhl049-098	B. WING		07/2	20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
STICKNE	Y HOUSE		WELL LOOP			
	CUMMADV CT		ILLE, NC 281	PROVIDER'S PLAN OF CORRECTION		0.00
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
V 736	Continued From page	11	V 736			
V 750	revealed: -the Owner had purch some other facilities ir -they had been workir all the facilities but har making all repairs yet. Interview on 7/19/18 v -he had purchased the other facilities in May -he was aware there v be completed and the working on those.	ng to make improvements in d not gotten around to vith the Owner revealed: e facility along with some	V 750			
	Water Systems 10A NCAC 27G .0304 EQUIPMENT (b) Safety: Each facili constructed and equip ensures the physical s visitors.	ty shall be designed, sped in a manner that safety of clients, staff and echanical and water				
	This Rule is not met a Based on observations failed to ensure electri maintained and in ope findings are:	s and interviews, the facility cal systems were		Electricion appt. 8,9.18 -Repairs TBD pending electric Findings, auticipatel complé	tion?	8,9,18 8,25.18
	pm of the facility revea	18 from 10:09 am - 3:59 aled: g room and office/therapy				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WNG 07/20/2018 mhl049-098 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 ROCKWELL LOOP STICKNEY HOUSE MOORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 750 V 750 Continued From page 12 - See previous pg. room constantly flickered; -the light in the pantry was not working. Interview on 7/19/18 with staff #1 revealed the light in the dining room had been flickering for several weeks and she had gotten used to it. Interview on 7/19/18 with the Associate Professional revealed: -"The lights flickering drive me crazy;" -"I think we have an electrical problem because when we print, it makes the lights worse;" -she thought the light not working in the pantry was due to the electrical problem they were having; -she was aware that flickering lights made some health conditions such as epilepsy worse. Interview on 7/19/18 with the Operations Manager revealed he was aware of the electrical issue and had been working on it. Completed 8/3/17



ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

July 25, 2018

Thelma Miller Rockwell Development Center, Inc. 120 Rockwell Loop Mooresville, NC 28115

Re: Annual and Complaint Survey completed July 20, 2018

Stickney House, 120 Rockwell Loop, Mooresville, NC 28115

MHL # 049-098

E-mail Address: tmiller@rdckids.com

Intakes #NC00140961, #NC00141041 and #NC00141103

DHSR - Mental Health

AUG 082018

Lic. & Cert. Section

Dear Ms. Miller:

Thank you for the cooperation and courtesy extended during the annual and complaint survey completed July 20, 2018. Two of the complaints were substantiated and one was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

All tags cited are standard level deficiencies.

Time Frames for Compliance

 Standard level deficiencies must be corrected within 60 days from the exit of the survey, which is September 18, 2018.

What to include in the Plan of Correction

 Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION