Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl049-098	A. BUILDING: ______ B. WING ______	R **10/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STICKNEY HOUSE	**120 ROCKWELL LOOP MOORESVILLE, NC 28115**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 rule violation was completed on October 10, 2019. This was a limited follow up survey, only 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (Tag V109) was reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (Tag V109). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.1700 Residential Treatment Staff Secure for Adolescents and Children.	V 000		

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