STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		mhl049-098	B. WING		R-C 07/29/2022
					1 07/29/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT KWELL LOOP	E, ZIP CODE	
STICKNE	Y HOUSE		SVILLE, NC 2811	5	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
V 440	on 7/29/22. Three of t substantiated (NC001 NC00190249) and on unsubstantiated (NC00 were cited. This facility is licensed category: 10A NCAC 3 Treatment Staff Secur Adolescents. This facility is licensed census of 4. The survey audits of 2 current clief	89508, NC00190168, and e complaint was 0190308). Deficiencies I for the following service 27G .1700 Residential e for Children or I for 4 and currently has a ey sample consisted of ints and 1 former client.			
V 110	SUPERVISION OF PA (a) There shall be no paraprofessionals. (b) Paraprofessionals associate professional professional as specifi Subchapter. (c) Paraprofessionals knowledge, skills and a population served. (d) At such time as a employment system is then qualified profession	COMPETENCIES AND RAPROFESSIONALS privileging requirements for shall be supervised by an or by a qualified ed in Rule .0104 of this shall demonstrate abilities required by the competency-based established by rulemaking, onals and associate nonstrate competence. be demonstrated by cluding: ge;	V 110	RECEIVED AUG 15 2022 DHSR-MH Licensure Sect	

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 (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl049-098	B. WING		l contract to the contract to	R-C	
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE ZIP CODE	0	7/29/2022	
			KWELL LOOP	ATE, ZII GODE			
STICKNE	THOUSE	MOORE	SVILLE, NC 281	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETE DATE	
V 110	(4) decision-making; (5) interpersonal skil (6) communication s (7) clinical skills. (f) The governing boddevelop and impleme	ls; kills; and dy for each facility shall nt policies and procedures individualized supervision paraprofessional.	V 110				
	Based on record reviet facility failed to ensure paraprofessional (staff	ews, and interviews the e 1 of 1 audited f #1) demonstrated abilities required by the					
	Review on 7/29/22 of revealed: -A hire date of 11/2/12 -A title of Paraprofessi						
	completed 5/3/22 but r -"[Client #1] states that consumed alcohol that weekend from the neigh -"[Client #3] states that weekend from a neigh Interview on 7/22/22 w Professional revealed:	t [former client (FC) #4] had t they had gotten over the ghbors;" t they got alcohol over the bor;" vith the Licensed					
	weekend prior to the d 5/9/22;	ad obtained alcohol the ischarge of FC #4 on					

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 2	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	mhl049-098	B. WING		R-C 07/29/2022
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	7 77720722
STICKNEY HOUSE		SKWELL LOOP SVILLE, NC 28115		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
the street and happer -"My number one que when all of this happer -"It should have been -She was not sure wh the incident. Interview on 7/25/22 of Manager revealed sta working when the incident Interview on 7/29/22 of -Staff #2 was inside the client #4; -She had taken clients where they asked to of -She observed the clie the road several times -"I had my eyes on the whole entire time;" -She saw the clients a couldn't tell what they -She asked the clients and they insisted that anything; -She thought to hersel right with me;" -She did not search the belongings; -She was not informed obtained alcohol at the telephone call after he -She visited the neight had provided the clien	were walking up and down need to see beer; estion was where was staff ened;" investigated;" no had been working during with the Human Resource off #1 and staff #2 had been dent occurred. with staff #1 revealed: ne facility processing with staff #3 and FC #4 outside walk; ents walking up and down streem (the clients outside) the staff the neighbors bush but were doing; swhat they had been doing they hadn't been doing they hadn't been doing elients or their that the clients had the bush until she received a reshift had ended; pors and asked them if they take with alcohol; ney had provided the clients	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		
		mhl049-098	B. WING		R-C 07/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
STICKNE	Y HOUSE		CKWELL LOOP SVILLE, NC 28115		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 114 Continued From page 3		MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 114	Continued From page	3	V 114		
V 114	27G .0207 Emergency	y Plans and Supplies	V 114		
	AND SUPPLIES (a) A written fire plan farea-wide disaster plath shall be approved by the authority. (b) The plan shall be rand evacuation proceed posted in the facility. (c) Fire and disaster dishall be held at least of repeated for each shift under conditions that see the shall be shall	n shall be developed and the appropriate local made available to all staff dures and routes shall be rills in a 24-hour facility			
	failed to ensure fire an completed quarterly and The findings are: Interviews on 7/29/22 of Manager and the Qual revealed: -Shifts consisted of 1st 3:30pm - 11:30pm, and -The QP was aware the were to be completed deach shift; -The QP was responsible disaster drills were consisted of the complete of t	w and interviews the facility d disaster drills were and repeated on each shift. with the Human Resource ified Professional (QP) 7:30am - 3:30pm, 2nd d 3rd 11:30pm - 7:30pm; at fire and disaster drills quarterly and repeated on the for ensuring all fire and impleted as required; at the fire and disaster that the fire and disaster			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
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NAME OF B	DOVIDED OD GUDDUED				OTTZ5/Z0ZZ
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	
STICKNE	Y HOUSE		KWELL LOOP		
			SVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 114	Continued From page	4	V 114		
	disaster drills complet June 2022 revealed: -There was not a 1st s documented for the 1st March 2022); -There was not a 3rd s documented for the 2rd June 2022).	the documented fire and ed between January 2022 - shift fire drill or disaster drill st quarter (January 2022 - shift fire drill or disaster drill and quarter (April 2022 - states a re-cited deficiency d within 30 days.			
V 367	27G .0604 Incident Re	eporting Requirements	V 367		
	level II incidents, exce the provision of billable consumer is on the pro incidents and level II d to whom the provider r 90 days prior to the inc responsible for the cat services are provided to becoming aware of the be submitted on a form Secretary. The report in person, facsimile or means. The report sha information: (1) reporting pro identification informatic (2) client identific (3) type of incide (4) description of	REMENTS FOR PROVIDERS providers shall report all pt deaths, that occur during e services or while the oviders premises or level III eaths involving the clients rendered any service within cident to the LME chment area where within 72 hours of e incident. The report shall in provided by the may be submitted via mail, encrypted electronic all include the following vider contact and on; cation information; ent;			

PRINTED: 08/03/2022 **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: _ R-C mhl049-098 B. WING 07/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 ROCKWELL LOOP STICKNEY HOUSE MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 Continued From page 5 V 367 cause of the incident; and other individuals or authorities notified or responding. (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: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2)reports by other authorities; and (3)the provider's response to the incident. (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

Division of Health Service Regulation

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). (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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 - 0.100 to compose to be one	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
STICKNE	Y HOUSE		KWELL LOOP				
			SVILLE, NC 28115				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 367	REGULATORY OR LSC IDENTIFYING INFORMATION)		V 367				
	The findings are: Review on 7/21/22 of a the Qualified Profession sent to the managing of revealed: -"[Former client (FC) # behaviors that have pure facility at risk;" -"She (FC #4) was IVC after four police response."	ws and interviews the all level II and Level III ging entity within 72 hours. a response completed by onal (QP) dated 5/11/22 and entity regarding a grievance					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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STICKNEY HOUSE 120 ROCK			DDRESS, CITY, ST KWELL LOOP SVILLE, NC 28			
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	behaviors, SI (suicidal homicidal threats;" -"On 5/2/22 [FC #4] at alcohol from a neighbor facility and was intoxic facility;" -"She (FC #4) became bottle and charged at a glass and attempted to broke into the group hidoor and stole a fork a before turning the fork. Review on 6/7/22 of In Improvement System (regarding FC #4 report Interviews on 7/21/22 arevealed: -She had worked at the just transitioned into the Just transitioned into the Just transitioned into IRIS; -The former QP had intentered the incident into provide verification. Interview on 7/22/22 we-she was aware that the #4 should have been eshe thought she had a IRIS but was not able to Interview on 7/22/22 with Interview	dideation) attempts, and disconded and retrieved bring house while at the sated on the premises of the divident and broke a beer the facility staff, she broke to stab facility staff, she then ome (sister facility) next and attempted to self-harm onto staff." Cident Response (IRIS) revealed no incidents ted since March 2022. And 7/29/22 with the QP Refacility for a while but had be QP spot this month; have entered the incident formed her that she had to IRIS but was not able to the incidents regarding FC intered into IRIS; entered the information into the provide documentation.	V 367			



Plan of Correction July 2022 Stickney House

Violation and Rules:

V110 27G .0204 Training/Supervision Paraprofessionals

10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.

RDC Violation:

This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure 1 of 1 audited paraprofessional (staff #1) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 7/29/22 of staff #1's personnel record revealed: -A hire date of 11/2/12; -A title of Paraprofessional. Review on 7/21/22 of an Internal Investigation completed 5/3/22 but not signed revealed: -"[Client #1] states that [former client (FC) #4] had consumed alcohol that they had gotten over the weekend from the neighbors;" -"[Client #3] states that they got alcohol over the weekend from a neighbor;" Interview on 7/22/22 with the Licensed Professional revealed: -FC #4 and client #3 had obtained alcohol the weekend prior to the discharge of FC #4 on 5/9/22; -The clients said they were walking up and down the street and happened to see beer; -"My number one question was where was staff when all of this happened;" -"It should have been investigated;" -She was not sure who had been working during the incident. Interview on 7/25/22 with the Human Resource Manager revealed staff #1 and staff #2 had been working when the incident occurred. Interview on 7/29/22 with staff #1 revealed: -Staff #2 was inside the facility processing with client #4; -She had taken clients #1, #3 and FC #4 outside where they asked to walk; -She observed the clients walking up and down the road several times; -"I had my eyes on them (the clients outside) the whole entire time;" -She saw the clients at the neighbors bush but couldn't tell what they were doing; -She asked the clients what they had been doing and they insisted that they hadn't been doing anything; -She thought to herself, "something ain't setting right with me;" -She did not search the clients or their belongings; -She was not informed that the clients had obtained alcohol at the bush until she received a telephone call after her shift had ended; -She visited the neighbors and asked them if they had provided the clients with alcohol; -The neighbors said they had provided the clients alcohol in the past but they had not recently.



Solution: In accordance with 10A NACAC 27G 0204 Competencies and Supervision of Paraprofessionals Rockwell Development Center will ensure documented staff meetings, supervision logs, and documented conversations are conducted on a monthly bases by Qualified Professional. All completed documentation will be located in the PQI binder located in the facility's main office. A staff meeting was conducted on 6/13/22, which reviewed supervision and safety protocols for all present consumers.

This deficiency has been corrected by ensuring all staff members are properly educated on how supervision is to be maintained for all consumers under RDC's care while on shift.

Violation and Rules:

V114 27G .0207 Emergency Plans and Supplies

10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.

RDC Violation:

This Rule is not met as evidenced by: V 114 Based on record review and interviews the facility failed to ensure fire and disaster drills were completed quarterly and repeated on each shift. The findings are: Interviews on 7/29/22 with the Human Resource Manager and the Qualified Professional (QP) revealed: -Shifts consisted of 1st 7:30am - 3:30pm, 2nd 3:30pm - 11:30pm, and 3rd 11:30pm - 7:30pm; -The QP was aware that fire and disaster drills were to be completed quarterly and repeated on each shift; -The QP was responsible for ensuring all fire and disaster drills were completed as required; -The QP was not aware that the fire and disaster drills were not being completed as required. Review on 7/21/22 of the documented fire and disaster drills completed between January 2022 - June 2022 revealed: -There was not a 1st shift fire drill or disaster drill documented for the 1st quarter (January 2022 - March 2022); -There was not a 3rd shift fire drill or disaster drill documented for the 2nd quarter (April 2022 - June 2022). This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

Solution: In accordance to 10A NCAC 27G .0207 Emergency Plans and Supplies, Rockwell Development Center will ensure that quarterly fire and disaster drills are performed and documented for each shift represented in a 24-hour facility. Rockwell Development Center will send out quarterly reminders to all Associate Professionals as a way to ensure completion.



This deficiency has been corrected by placing the fire and disaster tracking logs into the facilities D.O.G. (Daily Operations Guide) with marked year, month, day, time, shift, and personnel the emergency drill was performed. This form shall be easily accessible to all direct care staff for review. This will be reviewed by management monthly during treatment team meetings. Management spoke to AP's regarding this rule and ensure AP' was aware, reminded, and provided a counseling statement for the lack of compliance in the matter.

Violation and Rules:

V367 27G .0604 INCIDENT REPORTING REQIREMENTS

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. (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: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (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). (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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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.

RDC Violation:

This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report all level II and Level III incidents to the managing entity within 72 hours. The findings are: Review on 7/21/22 of a response completed by the Qualified Professional (QP) dated 5/11/22 and sent to the managing entity regarding a grievance revealed: -"[Former client (FC) #4] has had extensive behaviors that have put herself at risk and the facility at risk;" -"She (FC #4) was IVC'd (involuntarily committed) after four police responses on 5/2/2022 to our facility for AWOL (absent without official leave) behaviors, SI (suicidal ideation) attempts, and homicidal threats;" -"On 5/2/22 [FC #4] absconded and retrieved alcohol from a neighboring house while at the facility and was intoxicated on the premises of the facility;" -"She (FC #4) became violent and broke a beer bottle and charged at the facility staff, she broke glass and attempted to stab facility staff, she then broke into the group home (sister facility) next door and stole a fork and attempted to self-harm before turning the fork onto staff." Review on 6/7/22 of Incident Response Improvement System (IRIS) revealed no incidents regarding FC #4 reported since March 2022. Interviews on 7/21/22 and 7/29/22 with the QP revealed: -She had worked at the facility for a while but had just transitioned into the QP spot this month; -The former QP should have entered the incident into IRIS; -The former QP had informed her that she had entered the incident into IRIS but was not able to provide verification. Interview on 7/22/22 with the former QP revealed: -She was aware that the incidents regarding FC #4 should have been entered into IRIS; -She thought she had entered the information into IRIS but was not able to provide documentation. Interview on 7/22/22 with the Licensed Professional revealed it was the responsibility of the QP to enter incidents into IRIS.

Solution: In accordance to 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS Rockwell Development Center will report all level II incidents or fatalities that occur during the provision of billable service or while the consumer is on the providers premises to the Incident Response and Improvement System (IRIS) within 72 hours. Rockwell Development Center will also report any level II incidents and/or level III incidents involving the clients who the provider rendered any service within 90 days prior to the incident; the MCO 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 QP. The report may be submitted via mail, in person, facsimile or encrypted electronic means.

This deficiency has been corrected by addressing the mislabeling of the level of incident with the staff responsible. RDC management has addressed the need to have IR's signed by the QP, and not by the house manager (AP). This will ensure that the staff member who has been trained in IRIS reporting is making the determination that meets criteria for a level II/III report. The Clinical Manager communicated labeling with all staff during staff meeting and



Mantean Sp. 12022

through all staff email. The Clinical Manager additionally added IRIS reporting manuals to each house. The QP will monitor all corrections weekly for 6 months.



ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

August 4, 2022

Michelle Carroll, Human Resource Manager Rockwell Development Center, Inc. 11330 Vanstory Drive, Suite 115 Huntersville, NC 28078

Re:

Complaint and Follow Up Survey completed July 29, 2022 Stickney House, 120 Rockwell Loop, Mooresville, NC 28115

MHL # 049-098

E-mail Address: admin@rdckids.com

Intake #'s NC00189508, NC00190168, NC00190249, NC00190308

Dear Ms. Carroll:

Thank you for the cooperation and courtesy extended during the complaint and follow up survey completed July 29, 2022. Three complaints were substantiated, and one was unsubstantiated.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

• Re-cited standard level deficiency must be *corrected* within 30 days from the exit of the survey, which is August 28, 2022.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

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

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

• Standard level deficiencies must be *corrected* within 60 days from the exit of the survey, which is September 27, 2022.

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.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,

Sheri Spicer

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org dhhs@vayahealth.com

Shori Spicer

Pam Pridgen, Administrative Supervisor