

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-057	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2018
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NAME OF PROVIDER OR SUPPLIER SOUTH MOORE DRIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 109 SOUTH MOORE DRIVE ROXBORO, NC 27573
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(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 An annual survey was completed on March 13, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living/Alternative Family Living.	V 000	DHSR-Mental Health APR 17 2018 Lic. & Cert. Section	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Carlos Scott, Administrator 4/11/18
TITLE _____ (X6) DATE _____

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V 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observation, the facility staff failed to assure: 1) medication was administered as ordered by the physician for 1 of 3 clients (#1); 2) medication was available to be administered as ordered for 1 of 3 clients (#1); 3) physician's orders were available for all medications being administered and 4) the MAR was kept current affecting 3 of 3 clients (#1; #2 & #3.) The findings are:</p> <p>Review on 3/1/18 of Client #1's chart revealed: - Admission date 7/7/11 - Diagnoses of Depression, Intellectual Disability; Hypertension; Edema; Constipation and Hypersensitivity - No physician's orders were available in the facility for medications being administered.</p> <p>Review on 2/27/18 of Client #1's MARs from June 2017 through February 2018 revealed the following instructions were transcribed for medications and medical care: - Tenormin 25mg (Atenolol) one tablet daily (Used for lowering blood pressure.) - MAPAP 500mg, One tablet every 6 hours as needed (PRN) for pain. No more than six tablets in 24 hours. - Naproxen 500mg, One tablet twice each day as needed for pain. - Promethazine (Phenergan) HCL 25mg, One tablet every 6 to 8 hours as needed for nausea. - "Check blood pressure weekly."</p> <p>Additional review on 2/27/18 of Client #1's June</p>	V 118	<p>V 118: Client #1 Nursing will coordinate with Physicians, QP and AFL providers to receive updated and signed physician orders in a timely manner. A copy of request will remain on hand to verify coordination. Nursing will assure all PRN meds are ordered and placed in the home. Space will be provided on the MAR and Blood Pressure flow sheet will be added to MAR for weekly documentation of Blood pressure. Nursing will inservice providers on medication administration. Monitoring to ensure medications are administered without error through one medication observation per week for one month by nursing and or clinical team and then an on a routine basis. In the future the nursing will ensure staff are trained to administer medication without error.</p>	04/27/18
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V 118	<p>Continued From page 2</p> <p>2017 through February 2018 MARs revealed:</p> <ul style="list-style-type: none"> - Handwritten and printed instructions on the MARs to administer Tenormin 25mg as "One-half tablet daily (12.5mg.)" - Staff documentation that Tenormin 25mg was administered as 12.5mg (half of 25mg tablet) each day. - No documentation of weekly blood pressure checks. <p>Observation on 2/27/18 of Client #1's medications-on-hand at 4:30 PM revealed:</p> <ul style="list-style-type: none"> - One bottle of Tenormin 25mg, dispensed on 8/30/17, administration instructions - "1 tablet daily," contained approximately 10 tablets and 2 small chips of the originally dispensed 90 tablets. - The following PRN medications were not available for administration: MAPAP 500mg; Naproxen 500mg; Promethazine (Phenergan) HCL 25mg, and Aspirin 81mg. <p>During interview on 2/27/18, the Facility Operator/Staff confirmed:</p> <ul style="list-style-type: none"> - She did not have copies of the physician's orders for any client. - The Registered Nurse (RN) in the management office keeps copies of physician's orders and provides the monthly MARs with instructions for her to follow. - She transcribed any new information on the MAR for all new medication the doctor prescribed if the RN has already printed a monthly MAR. - She cut Client #1's Tenormin 25mg in half before administering the medication. She believed the doctor reduced the dose during a visit last year. However, she did not have a copy of a written order. - She picked up Client #1's medications from the pharmacy after the doctor ordered the medication. However, she did not check the 	V 118		
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V 118	<p>Continued From page 3</p> <p>strength or dosage of the medication.</p> <ul style="list-style-type: none"> - She did not take the client's blood pressure each week. His blood pressure was checked only during doctor's visits. <p>Review on 3/1/18 of the physician's orders maintained by the agency's RN for Client #1's medications revealed orders included the following as dated:</p> <ul style="list-style-type: none"> - 12/17/17: Tenormin 25mg, 1 tablet each day (for blood pressure) - 12/14/17: MAPAP 500mg, One tablet every 6 hours as needed for pain. No more than six tablets in 24 hours. - 12/14/17: Naproxen 500mg, One tablet twice each day as needed for pain. - 12/14/17: Promethazine (Phenergan) HCL 25mg, One tablet every 6 to 8 hours as needed (PRN) for nausea and - 2/2/18: Aspirin 81mg (no administration instructions) <p>Review on 2/27/18 of Client #2's chart revealed:</p> <ul style="list-style-type: none"> - No admission date. - Diagnoses of Schizophrenia, Undifferentiated; Psychosis; Mild Intellectual Disability; Bilateral Hearing Loss; Hyperlipidemia; Hypercholesterolemia and Constipation. - No physician's orders for medications being administered. <p>Review on 2/27/18 of Client #2's MARs for January 2018 and February 2018 revealed:</p> <ul style="list-style-type: none"> - For January 2018, documentation of the following were administered: <ol style="list-style-type: none"> a. Olanzapine (Zyprexa) 10mg, one tablet daily at bedtime (antipsychotic; used for treatment of Schizophrenia) b. Pravastatin Sodium 20mg, one tablet daily at bedtime (used for lowering cholesterol) 	V 118	<p>V 118: Client #2 Nursing will coordinate with Physicians, QP and AFL providers to receive updated and signed physician orders in a timely manner. A copy of request will remain on hand to verify coordination. Nursing will assure all PRN meds are ordered and placed in the home. Space will be provided on the MAR. Nursing will inservice providers on medication administration. Monitoring to ensure medications are administered without error through one medication observation per week for one month by nursing and or clinical team and then an on a routine basis. In the future the nursing will ensure staff are trained to administer medication without error.</p>	04/27/18
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V 118	<p>Continued From page 4</p> <p>c. Magnesium Chelated 27mg, two tablets twice daily; (used for nervous system support and anxiety relief)</p> <p>d. Docusate Sodium 100mg, one capsule daily at 8:00 AM and one at 8:00 PM (used for relief of constipation)</p> <p>e. Ferrous Sulfate 325mg, One tablet each day at 8:00 AM and one at 8:00 PM (used to prevent low blood levels of iron)</p> <p>f. Oyster Shell Calcium 500mg plus Vitamin D, One tablet each day at 8:00 AM and one at 8:00 PM (However, no administration instruction were transcribed on January MAR)</p> <p>g. Loratadine (Claritin) 10mg, one tablet one time each day (allergy relief)</p> <p>- No documentation on the February 2018 MAR, the client was administered any of the above identified medications.</p> <p>Observation on 2/27/18 of Client #2's medications-on-hand at 4:45 PM revealed:</p> <p>- No medication identified as Olanzapine (Zyprexa) 10mg was found.</p> <p>- Medications found included:</p> <p>a. Pravastatin Sodium 20mg, dispensed 1/29/18</p> <p>b. Magnesium Chelated 27mg, dispensed 1/29/18 with administration instructions for "One tablet 4 times each day"</p> <p>c. Docusate Sodium 100mg, dispensed 2/16/18 with administration instructions for "One capsule two times daily and at bedtimes as needed."</p> <p>d. Ferrous Sulfate 325mg, dispensed 2/16/18</p> <p>e. Oyster Shell Calcium 500mg plus Vitamin D, Over-the-counter (OTC) container. General instructions for 1 to 2 tablets three times a day with a meal. However, no administration instruction specifically for Client #2.</p> <p>f. Loratadine (Claritin) 10mg, dispensed on 1/24/18</p>	V 118		

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V 118	<p>Continued From page 5</p> <p>Review on 3/1/18 of physician's orders maintained by the RN for Client #2's medications revealed:</p> <ul style="list-style-type: none"> - Physician Orders for: - 1/2/18: Magnesium Chelated 27mg, two tablets twice each day - 2/2/18: Docusate Sodium 100mg with no instructions for administering the medication. - 2/2/18: Loratadine 10mg with no instructions for administering the medication. - No orders for: <ul style="list-style-type: none"> a. Ferrous Sulfate 325mg to be administered as one tablet each day at 8:00 AM and one at 8:00 PM; b. Oyster Shell Calcium 500mg plus Vitamin D, administered as one tablet each day at 8:00 AM and one at 8:00 PM c. Discontinue Olanzapine (Zyprexa) 10mg, one tablet daily at bedtime. (Documented as administered in January 2018. No documentation in February 2018) <p>Review on 2/27/18 of Client #3's chart revealed:</p> <ul style="list-style-type: none"> - Admission date of 2/20/12. - Diagnoses of Schizophrenia; Moderate Intellectual Disability; Seizure Disorder; Thyroid Disease; High Cholesterol; Hypertension; Calcium Metabolism Disorder; History of Kidney Disease, Leukemia and Seizure Disorder. - No physician's orders for medications being administered. <p>Review on 2/27/18 of Client #3's MARs for January 2018 and February 2018 revealed the following:</p> <ul style="list-style-type: none"> - Transcription and staff documentation for the following medication: <ul style="list-style-type: none"> a. Levothyroxine 112 mcg, One tablet daily (used for treatment of thyroid conditions) b. Donepezil (Aricept) 5mg (on January MAR) 	V 118	<p>V 118: Client #3 Nursing will coordinate with Physicians, QP and AFL providers to receive updated and signed physician orders in a timely manner. A copy of request will remain on hand to verify coordination. Nursing will assure all PRN meds are ordered and placed in the home. Space will be provided on the MAR and Blood Pressure flow sheet will be added to MAR for weekly documentation of Blood pressure. Nursing will inservice providers on medication administration. Monitoring to ensure medications are administered without error through one medication observation per week for one month by nursing and or clinical team and then on a routine basis. In the future the nursing will ensure staff are trained to administer medication without error.</p>	04/27/18

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V 118	<p>Continued From page 6</p> <p>and Donepezil 10mg (on February MAR) - (for treatment of dementia and prevention of Alzheimer's disease)</p> <p>Observation on 2/27/18 of Client #3's medications-on-hand at 5:00 PM revealed:</p> <ul style="list-style-type: none"> - A bottle of Levothyroxine 125 mcg, originally dispensed as 30 tablets on 12/27/17 with instructions to administer one tablet every day. Approximately eight tablets remained in the bottle. No Levothyroxine 112 mcg was available. - A bottle of Donepezil 10mg, dispensed on 2/17/18 with instructions to administer as one tablet daily. No bottle of Donepezil 5mg was available. <p>Review on 3/1/18 of physician's orders maintained by the RN for Client #3's medications revealed orders included the following as dated:</p> <ul style="list-style-type: none"> - 1/2/18: Levothyroxine 112 mcg, one tablet daily. - No order for Donepezil 5mg nor Donepezil 10mg. <p>Interview on 3/1/18 with the agency RN revealed:</p> <ul style="list-style-type: none"> - She provided the agency physician with each client's medication list to review and sign. - She does not obtain a copy of the original physician's order nor receive/review the actual medications. - She accepted the medication information provided to her by the Facility Operator/Staff after the client had a physician's visit. - She developed the client's MARs based on the staff's information then provided the MARs to the Facility Operator/Staff each month. <p>During additional interview on 3/1/18, the agency RN reported:</p> <ol style="list-style-type: none"> 1. For Client #1: <ol style="list-style-type: none"> a. Physician's orders were not followed for 	V 118		
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V 118	<p>Continued From page 7</p> <p>administering Tenormin 25mg daily</p> <p>b. The client was administered Tenormin 12.5mg daily for June 2017 through February 2018, half of 25mg daily dose ordered for managing the client's blood pressure.</p> <p>c. Weekly blood pressure checks were not completed.</p> <p>d. Medications were not available to be administered PRN: MAPAP 500mg for pain; Naproxen 500mg for pain and Phenergan HCL 25mg for nausea.</p> <p>2. For Client #2:</p> <p>a. No physician's order was present to administer Olanzapine (Zyprexa) 10mg, one tablet daily at bedtime in January 2018 and no discontinue order for medication not documented as administered in February 2018</p> <p>b. No orders signed by a physician for:</p> <ul style="list-style-type: none"> - Pravastatin Sodium 20mg administered as one tablet daily at bedtime - Ferrous Sulfate 325mg administered as one tablet each day at 8:00 AM and one at 8:00 PM; - Oyster Shell Calcium 500mg plus Vitamin D, administered as one tablet each day at 8:00 AM and one at 8:00 PM; - Loratadine (Claritin) 10mg administered one tablet each day. <p>c. MAR was not kept current identifying all medications being administered.</p> <p>d. Instructions on the pharmacy label for administering the medication Magnesium Chelated 27mg was not transcribed on the MAR.</p> <p>3. For Client #3:</p> <p>a. No signed physician's order for:</p> <ul style="list-style-type: none"> - Levothyroxine (Synthroid) 125 mcg, administered as one tablet daily - Donepezil 5mg documented on January MAR as administered one tablet daily - Donepezil 10mg documented on February 2018 as administered one tablet daily 	V 118		
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V 118	<p>Continued From page 8</p> <p>b. She transcribed the client's dose of Levothyroxine (Synthroid) from "125 mcg daily" to "112 mcg daily" when she "updated" his MARs without checking if the pharmacy received the escript from the client's physician.</p> <p>c. The client should have had a blood draw to review his levels as related to the use of Levothyroxine. However, she was unable find current blood test to review. Most recent test occurred in the past year (date not provided.)</p> <p>4. She requested clarification from the client's physician on dose and administration orders for all medications for all clients.</p> <p>Additional review on 3/9/18 of the physician's clarification of orders revealed: - All of the following orders provided by the RN were dated 3/6/18:</p> <p>1. for Client #1: a. Tenormin should be administered as 25mg daily not as 12.5mg b. Blood pressure should be checked weekly</p> <p>2. for Client #2: a. Pravastatin Sodium 20mg order for one tablet daily at bedtime b. Ferrous Sulfate 325mg should be administered as "One tablet every other day," not two times daily. c. Order for Oyster Shell Calcium 500mg plus Vitamin D as one tablet two times each day. d. Administration instructions were obtained for Docusate Sodium 100mg - one capsule daily PRN, not one tablet twice daily. e. Administration instructions were obtained for Loratadine 10mg - one capsule daily PRN not one tablet daily.</p> <p>3. for Client #3: a. Physician ordered staff to continue administering Levothyroxine (Synthroid) as 125 mcg daily until the client's next scheduled blood</p>	V 118		

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V 118	<p>Continued From page 9</p> <p>draw (scheduled 3/13/18) could be reviewed.</p> <p>b. Order for Donepezil 10mg to be administered as one tablet daily</p> <p>During interview on 3/9/18, the agency RN confirmed:</p> <ul style="list-style-type: none"> - All available physician's orders did not contain clear information about dose and instructions for administering medications. - All dose and administration instructions do not match dose and administration instructions for medications as dispensed by the pharmacy. - All dose and administration instructions transcribed on the MARs and administered by the staff were not kept current. <p>Review on 3/13/18 of the Plan of Protection dated 3/12/18 written by the agency's RN revealed: What immediate action will the facility take to ensure the safety of all consumers in your care? "I have transferred all medications to our pharmacy to be dispensed in Blister/Bubble packs effective 3/12/18. Any 1/2 tabs will be dispensed by pharmacy for accurate dose. All PRN medications are available in the home. Describe your plans to make sure the above happens. "Effective immediately all medication will be prescribed by nuscriptRx for all AFL (Adult Family Living) homes and checked by RN before being released. At the end of the month all old med packs will be returned to RN with completed MAR. All new Rx or medication changes will be submitted to RN immediately following physician appointments. Consult sheets have been provided by RN for all appointments. RN will handle all medication changes."</p> <p>Client #1's diagnoses included High Blood Pressure. For a period of at least nine months,</p>	V 118		

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V 118	<p>Continued From page 10</p> <p>Facility Manager/Staff at the AFL facility gave Client #1 only one-half the dose (12.5mg) of medication (Tenormin 25mg) his doctor prescribed to manage his high blood pressure. Additionally, the client did not have his blood pressure checked each week as the doctor ordered.</p> <p>Client #3's diagnoses included Thyroid Disease. On January 2, 2018, his physician reduced the strength of Levothyroxine prescribed to manage his thyroid condition from 125 mcg to 112 mcg. Staff continued to administer the Levothyroxine in the original dose of 125 mcg. The RN had not checked to make sure staff coordinated with his physician for regular required blood test related to taking this medication and was not aware of the physician's order to reduce the dosage until the survey.</p> <p>The Facility Manager/Staff did not have copies of the doctor's orders to check the medications dispensed by the pharmacy and determine if she received the medications ordered and if the medications were of the strength and dose the physician prescribed. She administered medication based on the instructions the agency RN put on the MAR and provided to her each month. The RN accepted information about medications she received from the Facility Manager/Staff. She did not check actual medications-on-hand to determine if medications dispensed by the pharmacy and being administered to clients were those the clients' physicians ordered. The failure to assure medications were administered as ordered and monitor blood pressures impacted client's health, safety and welfare.</p> <p>This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL073-057	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2018
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NAME OF PROVIDER OR SUPPLIER SOUTH MOORE DRIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 109 SOUTH MOORE DRIVE ROXBORO, NC 27573
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(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 118	Continued From page 11 imposed for each day the facility is out of compliance beyond the 45th day.	V 118		

To:	Maryland M. Chenier	Fax:	919-715-8078	
From:	M. Thomas	Date:	04/13/18	
Re:		Pages:	14 (Including Cover)	
CC:	Bryson Brown			
Urgent	For Review	As Requested	Please Reply	Please Recycle

Additional Comments: Please review. Original will be mailed.

Confidentiality Note: The enclosed facsimile transmission contains confidential medical record information. This information has been disclosed to the recipient identified above and is protected by State and Federal law. Those laws limit your ability to further disclose this confidential medical information without the prior written consent of the patient/client and his/her legal guardian or unless otherwise permitted by State and Federal law. If you are not the intended recipient, you are hereby notified that any USE, disclosure, copying, distribution, or OTHER action taken WITHOUT RESPECT TO the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Last Modified: 7/7/2006

Form #: 2011-RTP

DATE, TIME	04/13 15:06
FAX NO./NAME	19197158078
DURATION	00:05:32
PAGE(S)	15
RESULT	OK
MODE	STANDARD

TIME : 04/13/2018 15:12
NAME :
FAX :
TEL :
SER.# : U63315M6J376548

TRANSMISSION VERIFICATION REPORT



RHA Health Services, LLC
 2527 E. Lyon Station Rd
 Creedmoor, NC 27522
 Phone: 919-528-2558
 Fax: 919-528-2971

FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 2, 2018

Mr. Carlos Scott, Administrator
RHA Health Services NC, LLC
2527 E Lyon Station Rd.
Creedmoor, NC 27522

Re: Annual Survey completed March 13, 2018
South Moore Drive, 109 South Moore Drive, Roxboro, NC 27573
MHL # 073-057
E-mail Address: cscott@rhanet.org

Dear Mr. Scott:

Thank you for the cooperation and courtesy extended during the annual survey completed March 13, 2018.

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

- Type B rule violation is cited for 10A NCAC 27G .0209 MEDICATION REQUIREMENTS

Time Frames for Compliance

- Type B violation must be **corrected** within 45 days from the exit date of the survey, which is April 27, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45th day from the date of the survey may result in the assessment of an administrative penalty of \$200.00 (Two Hundred) against RHA Health Services NC, LLC for each day the deficiency remains out of compliance.

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.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

WWW.NCDHHS.GOV

TEL 919-855-3795 • FAX 919-715-8078

LOCATION: 1800 UMSTEAD DRIVE • WILLIAMS BUILDING • RALEIGH, NC 27603

MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER



4/2/18

South Moore Drive

Mr. Carlos Scott

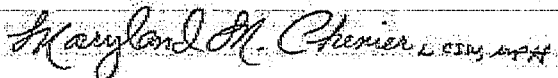
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original 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 Mr. Bryson Brown at 919-855-3832.

Sincerely,



Maryland M. Chenier, MSW, LCSW, MPH
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Suttan, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File