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	MHL032-412	A. BUILDING: _____ B. WING _____	07/27/2018

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 7/27/18. The complaint was unsubstantiated (intake #NC00139847). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment, 10A NCAC 27G . 4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G . 4500 Substance Abuse Comprehensive Outpatient Treatment Program The client census was 428 at the time of the survey.	V 000	RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 2:41 pm, Aug 14, 2018	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need;	V 105		

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V 105	Continued From page 1 (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policy regarding testing positive for Benzodiazepine. The findings are: Review on 7/26/18 of the facility's policy on Benzodiazepine revealed the policy included the following components: -"All patients testing positive for illicit Benzodiazepines are to meet with the Medical Director of the clinic(s) within (7) days of the results. Patients will meet monthly with the physician until no longer test positive for Benzodiazepines." -"Patients testing positive for Benzodiazepine 4-6 months post admission are to be referred to Medical Director of the clinic(s). The amount and type of Benzodiazepine will be ascertained, understanding that both are inaccurate during the initial interview of the patient." -"Patients testing positive for illicit Benzodiazepines will have weekly documented counseling sessions until they no longer test positive for Benzodiazepines." Review on 7/26/18 of Deceased Client (DC) #21's chart revealed: -Admission date of 8/9/16. -Diagnoses of Opioid Dependence; Cocaine Use Disorder; Bipolar Disorder; Borderline Personality Disorder, Diabetes; Hypothyroidism. -DC #21 died on 5/22/18. -Methadone dosage was 50 mg. Review on 7/25/18 of an incident report for DC #21 revealed: -Date of Incidence: 5/22/18.	V 105		

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V 105	Continued From page 3 -Location of the Incident: Consumer's Home. -Level of Incident: Level III. -Suspected Cause of Death: Accidental Overdose -DC #21 dosed at 50 mg that morning and apparently died in afternoon. -DC #21's roommate stated that she had been using benzodiazepines, cocaine and heroin, and staying with an abusive boyfriend. Review on 7/26/18 of DC #21's Urine Drug Screens (UDS) revealed: -5/8/18 was positive for Benzodiazepine, Cocaine and Codeine. -3/28/18 was positive for Benzodiazepine and Cocaine. -2/5/18 was positive for Benzodiazepine and Cocaine. -1/9/18 was positive for Benzodiazepine and Cocaine. -12/15/17 was positive for Benzodiazepine and Alcohol. -11/9/17 was positive for Benzodiazepine and Cocaine. -10/27/17 was positive for Benzodiazepine and Alcohol. -9/7/16 was positive for Benzodiazepine and Alcohol. -8/9/16 was positive for Benzodiazepine. Review on 7/26/18 of DC #21's list of medications revealed: -Insulin 60 units daily. -Neurontin 600 mg- Three times a day. -Cymbalta 60 mg- One tablet daily. -Synthroid 275 mcg- One tablet daily. -Trazodone 200 mg- One tablet at night. -Seroquel 200 mg- One tablet in the morning. -Seroquel 400 mg- One tablet at night. -No Benzodiazepine medication was being prescribed.	V 105		

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V 105	Continued From page 4 Review on 7/26/18 of DC #21's case notes revealed: -She met with the counselor on 12/27/17, 3/27/18, 5/8/18 and 5/22/18. -She met with the physician assistant on 1/19/18. -She met with the physician on 1/22/18 and 5/8/18. -Physician did not meet with DC #21 within seven days after she tested positive for Benzodiazepine. -There were no weekly documented counseling sessions while DC #21 continued to test positive for Benzodiazepine. -There were no monthly meetings with the physician while DC #21 continued to test positive for Benzodiazepine. Interview on 7/25/18 and 7/27/18 with the Counseling Supervisor revealed: -The Clinic staff were informed on 5/24/18 that DC #21 had died from an overdose on 5/22/18. -DC #21 had dosed at the clinic on 5/22/18. -She met with DC #21 on 5/22/18 prior to her death. -She talked with DC #21 about Narcan. -DC #1 seemed to be "dismissive" and told her she already had Narcan. -The clinic staff were aware DC #21 consistently tested positive for Benzodiazepines and other substances. -The Clinic Physician did not meet with DC #21 within seven days after she tested positive for Benzodiazepine. -A former Counselor did meet with DC #21 for continued Benzodiazepine use, however it was not on a weekly basis. -She was aware there were no weekly documented counseling sessions for continued positive testing of Benzodiazepines. -She was aware there were no monthly meetings	V 105		

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V 105	Continued From page 5 with the physician while DC #21 continued to test positive for Benzodiazepines. -She confirmed the facility failed to follow their Benzodiazepine policy for DC #21. Interview on 7/27/18 with the Clinic Director confirmed: -Facility staff failed to follow Benzodiazepine policy for DC #21. Review on 7/27/18 of a Plan of Protection written by the Counseling Supervisor and Clinic Director dated 7/27/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm: "Effective 7/27/18, a Methasoft report will be run daily, identifying all benzodiazepine positive patients' drug screens for that day. All patients testing positive will be placed on hold in Methasoft, will see their Counselor prior to dosing. Session will be held with Counselor regarding benzodiazepine positive results. An Appointment will be scheduled during the Counselor session with [Medical Director] that will fall within the seven day requirement." Describe your plans to make sure the above happens: "A spread sheet will be developed and maintained that includes all patient record numbers/names that tested positive for benzodiazepines. Spreadsheet will include a column for the follow-up date with the Counselor as patient verification. Date of [Medical Director] appointment schedule will be included on spreadsheet. Column to ensure [Medical Director] appointment took place will be included on the spreadsheet. Spread sheet will be monitored by [Counseling Supervisor] daily. Spread sheet will be monitored weekly (Fridays) by [Clinic Director]."	V 105	Effective 7/27/18, a Methasoft report will be run daily, identifying all benzodiazepine positive patients' drug screens for that day. All patients testing positive will be placed on hold in Methasoft, and will see their Counselor prior to medicating. Session will be held with Counselor regarding benzodiazepine positive results. An Appointment will be scheduled during the Counselor session with the Medical Director that will fall within the seven-day requirement. Describe your plans to make sure the above happens: A spread sheet was developed on 7/27/18 that includes all patient record numbers and names that tested positive for benzodiazepines. Spreadsheet will include a column for the follow-up date with the Counselor as patient verification. Date of Medical Director appointment scheduled will be included on the spreadsheet. Column to ensure the Medical Director appointment took place will be included on the spreadsheet. Spreadsheet will be monitored by Counseling Supervisor daily. This spreadsheet will be updated daily by Clinical Supervisor and reviewed for accuracy every Friday by the Clinic Director.	

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V 105	*Continued From page 6* *DC#1 had diagnoses of Opioid Dependence, Cocaine Use Disorder, Bipolar Disorder, Borderline Personality Disorder, Diabetes and Hypothyroidism. DC #21 died on 5/22/18. It was reported that DC #21 died from an apparent overdose. Prior to her death DC #21 tested positive for Benzodiazepines and other substances seven times since 10/27/17. DC #21 did not meet with the Medical Director monthly as stated in the Benzodiazepine policy. DC #21 did not meet with a Counselor on a weekly basis as stated in the Benzodiazepine policy. The Clinic staff did not follow their policy to address continued use of Benzodiazepines. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $6000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.*	V 105	Counselor Supervisor will monitor the benzodiazepine spreadsheet for accuracy and completeness on a daily basis. The Clinic Director will review the spreadsheet every Friday.	
V 114	*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.*	V 114	BAART will follow its Health and Safety Plan as an addendum to the NC BAART Handbook that requires fire and disaster drills be conducted on a quarterly basis. A copy of the Emergency Safety Drill Report Form will be completed by the Safety Officer and/or Clinic Director. The Clinic Director will review the contents of the form for content and accuracy following the completion of the form. A copy of the form will be maintained in the Safety binder for the BAART location.	10/01/18

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V 114	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Review on 7/25/18 of the facility's fire and disaster drills record revealed: -There were drills conducted on the following dates: -3/31/17 and 4/25/18 - 1st shift fire drill -5/18/17 and 6/28/18 - 1st shift disaster drill -Fire and Disaster drills were not conducted at least quarterly. Interview on 7/27/18 with the Clinic Director revealed: -She was new to the position as of February 2018. -She was unaware fire and disaster drills needed to be conducted quarterly. -The facility operated on one shift. -She confirmed fire and disaster drills were not conducted at least quarterly.	V 114	An appointment alert will be entered in Microsoft Outlook, on a quarterly basis, two days before the drill is to take place. This will give the Clinic Director two days to prepare for the drill. This will ensure that no quarterly drills are overlooked for that particular quarter. This process will be utilized every quarter for at least two (2) drills per quarter. The Clinic Director will monitor the drills to ensure that they are being completed on a quarterly basis. Two weeks prior to each quarter, the Clinic Director will review the drills that have taken place and are filed in the Safety Binder and will match them against those that have not taken place. The Clinic Director will schedule the next set of quarterly drills based on those that have not yet taken place when the alert notifies the Clinic Director through Microsoft Outlook.	
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the	V 235	BAART enlisted their internal recruiting team to run a sponsored ad and help filter qualified candidates to the Program Director. Clinic Director Director and Counselor Supervisor will continue to reach out to these applicants immediately and schedule interviews. BAART is working to change the culture of their clinical staff and are seeking counselors with full licensure, or provisional licensure, for the vacant positions.	10/01/18

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V 235	Continued From page 8 certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients, facility failed to ensure at least one staff member on duty had training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction affecting two of nine audited staff (The Lead Nurse and Nurse #1) and failed to ensure each direct care staff member received continuing education in nature of addiction and the withdrawal syndrome affecting two of nine audited staff (The Lead Nurse and Nurse #1). The findings are: 1. The following is evidence the facility failed to ensure a minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients.	V 235	BAART also initiated a retention sign-on bonus program for counselors hired between August 6 and September 21, 2018 in effort to attract more candidates. BAART is aggressively interviewing counselors for the vacant positions. BAART is also offering a bonus program for counselors hired between August 6 and September 21, 2018. Interviews are being scheduled on a daily basis to comply with the ratio of 50:1. If the facility is unable to hire a non-certified person by the completion date, then BAART will hire certified staff who can meet the clinical requirements for licensure within 26 months following the date of employment. The Clinic Director and Counselor Supervisor will review the weekly census to review counselor assignments and caseloads to ensure that the ratio is 50:1. The Counselor Supervisor will make all needed adjustments to the caseloads and the Clinic Director will review every Friday to ensure that no counselor is over the threshold of 50:1.	

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V 235	Continued From page 9 Review of facility records on 7/25/18 revealed: -The facility had a census of 428 clients. -The facility currently had five full time substance abuse counselors. -Counselor #1 had a caseload of 75 clients. -Counselor #2 had a caseload of 75 clients. -Counselor #3 had a caseload of 74 clients. -Counselor #4 had a caseload of 75 clients. -Counselor #5 had a caseload of 74 clients. Interview on 7/25/18 with the Counseling Supervisor revealed: -She did currently have a caseload of clients due to the Counselor vacancies. -She thought Counselors who had more than 50 on their caseloads just occurred within the last month. -She confirmed the facility failed to ensure there was a ratio of one counselor to every 50 or less clients. Interview on 7/25/18 with the Clinic Director revealed: -The clinic currently has three vacant counselor positions. -The Counseling Supervisor had taken on a caseload of clients. -She had also taken on a caseload of clients. -Some of the Counselors did have more than 50 clients on their caseload. -She thought there were at least three Counselors who had more than 50 clients on their caseload. -She confirmed the facility failed to ensure there was a ratio of one counselor to every 50 or less clients. 2. The following is evidence the facility failed to ensure at least one staff member on duty had training in drug abuse withdrawal	V 235		

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V 235	Continued From page 10 symptoms/symptoms of secondary complications to drug addiction. a. Review on 7/25/18 of the facility's personnel files revealed: -The Lead Nurse had a hire date of 7/31/10. -There was no documentation of training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. b. Review on 7/25/18 of the facility's personnel files revealed: -Nurse #1 had a hire date of 12/27/17. -There was no documentation of training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. Interview with the Clinic Director on 7/25/18 revealed: -She was not aware of Nurses needing the training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. -She confirmed the Lead Nurse and Nurse #1 had no training in drug abuse withdrawal symptoms/symptoms of secondary complications to drug addiction. 3. The following is evidence the facility failed to ensure each direct care staff member received continuing education in nature of addiction and the withdrawal syndrome. a. Review on 7/25/18 of the facility's personnel files revealed: -The Lead Nurse had no documentation of continuing education in nature of addiction and the withdrawal syndrome. b. Review on 7/25/18 of the facility's personnel	V 235	BAART nurses and counselors are taking training courses through Relias Learning System that includes: 1) drug abuse withdrawal symptoms; 2) symptoms of secondary complications to drug addiction; 3) nature of addiction; (4) the withdrawal syndrome; (5) group and family therapy; (6) infectious diseases (HIV, sexually transmitted diseases and TB) The Clinic Director has requested that all employees print out certificates for completed tranings that will be filed in their individual personnel files. The Clinic Director will track and review all completed courses in Relias once a week and meet with those employees who have not completed them by the due date. All new hires for nurses and counselor positions will train on the recommended courses within two weeks of hire. The Clinic Director will monitor the personnel files weekly to ensure that all staff have completed trainings and certiicates are maintained in the personnel file.	08/31/18

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V 235	Continued From page 11 files revealed: -Nurse #1 had no documentation of continuing education in nature of addiction and the withdrawal syndrome. Interview with the Clinic Director on 7/25/18 revealed: -She was not aware of Nurses needing the continuing education in nature of addiction and the withdrawal syndrome. -She confirmed the Lead Nurse and Nurse #1 had no continuing education in nature of addiction and the withdrawal syndrome.	V 235		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 6, 2018

Vicki Friel, Regional Vice President
BAART Community Healthcare
800 North Mangum Street, Suite 400
Durham, NC 27701

Re: Annual and Complaint Survey completed July 27, 2018
BAART Community Healthcare, 800 North Mangum Street, Suite 400, Durham, NC, 27701
MHL # 032-412
E-mail Address: vfriel@baymark.com
Intake #NC00139847

Dear Ms. Vicki Friel:

Thank you for the cooperation and courtesy extended during the Annual and Complaint survey completed July 27, 2018. The complaint 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

- Type A1 rule violation is cited for 10A NCAC 27G .0201 Governing Body Policies-V-105.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is August 19, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against BAART Community Healthcare for each day the deficiency remains out of compliance.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is September 25, 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.).
- 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 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 Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Edgar Garrido
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Frances Hicks
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Trey Sutten, Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

August 6, 2018

Vicki Friel, Regional Vice President
BAART Community Healthcare
800 North Mangum Street, Suite 400
Durham, NC 27701

RE: Type A1 Administrative Penalty
BAART Community Healthcare, 800 north Mangum Street, Suite 400, Durham, NC
MHL # 032-412
E-mail Address: vfriel@baymark.com

Dear Ms. Friel:

Based on the findings of this agency from a survey completed on July 27, 2018, we find that BAART Community Healthcare has operated BAART Community Healthcare in violation of North Carolina General Statute (N.C.G.S.) § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities, and Substance Abuse Services. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A1 administrative penalty of $6,000.00 against BAART Community Healthcare for violation of 10A NCAC 27G .0201 Governing Body Policies (V105). Payment of the penalty is to be made to the Division of Health Service Regulation, and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 10% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

August 6, 2018
BAART Community Healthcare
Ms. Friel

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Lisa G. Corbett, General Counsel. This person may receive service of process by mail at the following address:

Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 919-397-6856. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Michiele Elliott, Eastern Branch Manager at 919-397-6856.

Sincerely,

Stephanie Gilliam

Stephanie Gilliam, Chief
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavior Health LME/MCO
Michael A. Becketts, Director, Durham County DSS
Smith Worth, SOTA Director
Pam Pridgen, Administrative Assistant
File