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
	140239	A. BUILDING: _____ B. WING _____	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERITAS COLLABORATIVE, LLC	4024 STIRRUP DRIVE DURHAM, NC 27703

(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 and complaint survey was completed on September 20, 2021. The complaints were unsubstantiated intake #NC00176982, NC00179906 and NC00180778. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances, 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents and 10A NCAC 27G .6000 Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or	V 112	27G.0205 Site leadership, in partnership with the Senior Clinical Director, Executive Director, and IT is remediating this standard through the optimization of the electronic health record in order to obtain patient signatures that demonstrates their agreement with and participation in creating and updating the treatment plan. In the event a signature is unable to be obtained via the electronic health record, staff will utilize an alternative method to demonstrate this standard (e.g. written signature on treatment plan). Applicable clinical staff will be re-trained on this treatment plan standard and the corresponding process. Ongoing conformance to this standard will be met through regular auditing of patient charts. Any gaps in treatment plans will be reviewed with site leadership and the applicable clinical staff member(s).	Will implement by 11/19/21 with ongoing conformance there-after.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Lamitra TITLE: Executive Director (X6) DATE: 10/1/2021

MH40972

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V 112	Continued From page 1 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have written consent or agreement by the client or responsible party affecting three of forty two current clients (#2, #3 and #4). The findings are: a. Review on 9/16/21 of client #2's record revealed: -Admission date of 8/12/21. -Diagnoses of Anorexia Nervosa, Bipolar Disorder, Amenorrhea, Abdominal Distension, Hyperlipidemia and Gastroesophageal Reflux Disease. -Date of birth was 7/17/05. -The date of the treatment plan was 8/12/21 and updated 9/8/21. -Client #2's treatment plan had no written consent or agreement by the client or responsible party. b. Review on 9/16/21 of client #3's record revealed: -Admission date of 9/2/21. -Diagnoses of Gastroparesis, Anorexia Nervosa, Obsessive Compulsive Disorder, Generalized Anxiety Disorder, Vitamin D Deficiency and Seborrhea Capitis. -Date of birth was 3/14/08.	V 112		

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V 112	Continued From page 2 -The date of the treatment plan was 9/3/21. -Client #3's treatment plan had no written consent or agreement by the client or responsible party. c. Review on 9/16/21 of client #4's record revealed: -Admission date of 8/6/21. -Diagnoses of Bulimia Nervosa, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Coronary Artery Disease, Cannabis Use Disorder, Insomnia and Vitamin D Deficiency. -Date of birth was 11/1/03. -The date of the treatment plan was 8/13/21 and updated 8/20/21. -Client #4's treatment plan had no written consent or agreement by the client or responsible party. Interview on 9/17/21 with the Executive Director revealed: -They use an electronic medical record system named "Aura." -The way it works with saving notes in the system is an issue. -It will not allow you to put a signature on a document when you first create the document. -Once that episode of care is closed out the treatment plan can then be signed. -She confirmed the facility failed to have written consent or agreement by the client or responsible party.	V 112		
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.	V 114	27G.0207 Led by the facilities' Executive Director, Site Trainer, and Nurse Manager, the facility will complete and document all required quarterly disaster drills with staff and patient participation, completing during all shifts. The facility will utilize	Will implement by 10/31/21 with ongoing conformance there-after

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V 114	Continued From page 3 (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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to conduct disaster drills under conditions that simulate emergencies. The findings are: Review of the facility's disaster drill log on 9/15/21 revealed: -3/10/21-1st shift -There was no documentation of any additional disaster drills completed for 2020 and 2021 by facility staff. Interview with client #1 on 9/17/21 revealed: -She had been at the facility for about three weeks. -Staff had never conducted a fire or disaster drill with them. Interview with client #2 on 9/17/21 revealed: -She had been at the facility for about five weeks. -She did not recall staff ever conducting a fire or disaster drill with them. Interview with client #3 on 9/17/21 revealed: -She had been at the facility for about two weeks. -Staff had not done any fire or disaster drills with	V 114	an emergency drill tracking sheet to schedule drills and verify ongoing conformance. The Compliance team will also perform regular check-ins with the Executive Director to verify this standard is met.	

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V 114	Continued From page 4 them. Interview with staff #1 on 9/20/21 revealed: -She thought they did a fire drill about a month ago. -They had not done any disaster drills at the facility. Interview with staff #2 on 9/20/21 revealed: -She thought they did a fire drill about a month ago with the clients. -They had not done any disaster drills, they did review the policy for those drills. Interview with staff #3 on 9/20/21 revealed: -She thought staff and clients did a fire drill about a month. -She did not recall the last time a disaster drill was not completed. Interview with the Executive Director on 9/15/21 revealed: -Staff work two separate shifts. Staff work 12 hour shifts. -The facility staff had been doing the disaster drills annually, not quarterly. -They normally do the one disaster drill during the statewide evacuation. -She confirmed staff failed to conduct disaster drills under conditions that simulate emergencies.	V 114		
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	V 118	27G.0209 The Executive Director and Nurse Manager, in partnership with Veritas' VP of Nursing, will retrain all nursing staff on standards of medication administration record documentation accuracy and completion. Nursing Leadership will verify ongoing	Will complete re-training and implement weekly auditing by 11/19/21

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V 118	Continued From page 5 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. This Rule is not met as evidenced by: Based on record reviews and interviews, facility staff failed to keep the MAR current affecting two of forty current clients (#1 and #2) and one of two audited former clients (FC #43). The findings are: a. Review on 9/16/21 of client #1's record revealed: -Admission date of 8/24/21	V 118	conformance with this standard through weekly auditing of each patient's medication administration record.	

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V 118	Continued From page 6 -Diagnoses of Anorexia Nervosa, Major Depressive Disorder, Adjustment Disorder with Anxiety, Obsessive Compulsive Disorder, Amenorrhea, Hyperlipidemia, Vitamin D Deficiency, Generalized Hyperhidrosis and Insomnia -Date of birth was 5/11/06 -Physician's order dated 8/25/21 for Simethicone Oral 125 milligrams (mg), one capsule three times daily. Review of a MAR for client #1 on 9/16/21 revealed: -September 2021 had a blank box on 9/1 for Simethicone Oral 125 mg medication. b. Review on 9/16/21 of client #2's record revealed: -Admission date of 8/12/21. -Diagnoses of Anorexia Nervosa, Bipolar Disorder, Amenorrhea, Abdominal Distension, Hyperlipidemia and Gastroesophageal Reflux Disease. -Date of birth was 7/17/05. -Physician's order dated 8/13/21 for Vitamin D 2000 units, one capsule at bedtime. Review of MAR for client #2 on 9/16/21 revealed: -August 2021 had a blank box on 8/22 for Vitamin D 2000 units medication. c. Review on 9/16/21 of FC #43's record revealed: -Admission date of 11/23/20. -Diagnoses of Reactive Attachment Disorder, Anxiety Disorder, Vitamin D Deficiency, Generalized Hyperhidrosis, Hyperlipidemia, Galactorrhea, Gastroesophageal Reflux Disease, Dorsalgia and Avoidant Restrictive Food Intake Disorder.	V 118		

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V 118	Continued From page 7 -Date of birth was 6/19/04. -Discharge date of 3/12/21. -Physician's order dated 11/24/20 for Cholecalciferol (D3-50) 1.25 mg, 5000 units, one capsule at bedtime every Tuesday for 8 weeks. Review of MAR's for FC #43 on 9/16/21 and 9/17/21 revealed: -January 2021-staff documented the Cholecalciferol was administered on 1/3/21, 1/5/21, 1/10/21 thru 1/13/21. -December 2020- staff documented the Cholecalciferol was administered on 12/1 thru 12/3, 12/7, 12/9, 12/14, 12/15, 12/22 and 12/29. -November 2020-staff documented the Cholecalciferol was administered on 11/25 thru 11/28. "Due to the failure to accurately document medication administration it could no be determined if clients received their medication as ordered by the physician" Interview with the Nurse Supervisor on 9/16/21 revealed: -She was not sure why client #1's Simethicone medication was not administered on 9/1/21. -She was not sure why client #2's Vitamin D medication was not administered on 8/22/21. -She confirmed staff failed to keep the MAR current for clients #1 and #2. Interview with the Nurse on 9/17/21 confirmed: -Nursing staff documented the Cholecalciferol medication was administered to FC #43 in November 2020, December 2020 and January 2021. Interview with the Compliance Manager on 9/17/21 revealed:	V 118		

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V 118	Continued From page 8 -An issue with the Cholecalciferol medication for FC #43 came to their attention in May 2021. -FC #43's mother brought this issue to their attention because she was concerned FC #43 got too much medication. -They got information from pharmacy that showed FC #43 did not receive as much of the Cholecalciferol as previously indicated on the MAR's. -FC #43 did not get too much of the Cholecalciferol medication. -Staff were documenting the medication was being given on days that it was not administered. -She confirmed staff failed to keep the MAR current for FC #43. Interviews with the Executive Director on 9/16/21 and 9/17/21 revealed: -FC #43's mother brought the Cholecalciferol medication error to their attention. -FC #43 really wasn't getting as many doses of the Cholecalciferol medication. They only received a certain amount of pills. -The pharmacy was only sending 4 pills at a time during those months. -They actually got a record from the pharmacy of the number of pills dispensed. -This was a documentation error by facility staff, FC #43 did not receive too many doses of the Cholecalciferol medication. -She confirmed staff failed to keep the MAR current for clients #1, #2 and FC #43.	V 118		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS	V 536	27E.0107 The facility's Site Trainer, in partnership with the Learning and Development Manager, Executive Director, and Senior Clinical Director, will identify clinical staff who did not receive and/or do not have current training on alternatives to restrictive interventions in their personnel file.	Will complete by 11/19/21 with ongoing conformance thereafter

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V 536	Continued From page 9 (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) 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. (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	V 536	All staff identified within this category will be appropriately trained on the use of alternatives to restrictive interventions. In addition, any newly hired clinical staff persons that have direct patient contact will be appropriately trained on the use of alternatives to restrictive interventions as a part of their routine onboarding and orientation. Completion of this training will be documented in each staff person's personnel/training file. In addition, the Site Trainer will continue to routinely audit training completion to ensure all current and future staff meet this training requirement.	

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V 536	Continued From page 10	V 536		

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 person's 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);
(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.
(2) Trainers shall demonstrate competence 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

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V 536	Continued From page 11 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 at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times	V 536		

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V 536	Continued From page 12 the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure two of seven staff (the Clinical Director and Psychotherapist) had training on the use of alternatives to restrictive interventions. The findings are: a. Review on 9/15/21 of the facility's personnel files revealed: - Hire date of 1/13/20. -The Clinical Director had a Nonviolent Crisis Intervention training certificate that expired on 1/14/21. -There was no documentation of current training on the use of alternatives to restrictive interventions for the Clinical Director. b. Review on 9/15/21 of the facility's personnel files revealed: - Hire date of 1/4/21. -The Psychotherapist had no documentation of training on the use of alternatives to restrictive interventions. Interview with the Executive Director on 9/15/21 revealed:	V 536		

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V 536	Continued From page 13 -The agency uses Nonviolent Crisis Intervention training on the use of alternatives to restrictive intervention. -The therapist and some of the other clinical staff are not required to have the alternatives to restrictive intervention training. -It was not a part of their agency policy for clinical staff to get that training. -She confirmed the the Clinical Director and Psychotherapist had no current training on the use of alternatives to restrictive intervention.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.	V 537	27E. 0108 The facility's Site Trainer, in partnership with the Learning and Development Manager, Executive Director, and Senior Clinical Director, will identify clinical staff who have not received and/or do not have current training in seclusion, physical restraint, and isolation time-out in their personnel file. All staff identified within this category will be appropriately trained through CPI on seclusion, physical restraint, and isolation time-out as outlined within this standard. In addition, any newly hired clinical staff persons that have direct patient contact will be appropriately trained in seclusion, restraint, and isolation time-out as a part of their routine onboarding and orientation. Completion of this training will be documented in each staff person's personnel/training file. In addition, the Site Trainer will continue to routinely audit training completion to ensure all current and future staff meet this training requirement.	Will complete by 11/19/21 with ongoing conformance there-after.

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	140239	A. BUILDING: _____ B. WING _____	09/20/2021

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V 537	Continued From page 14 (d) 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. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years.	V 537		

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V 537	Continued From page 15 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (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 Qualification 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. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least	V 537		

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V 537	Continued From page 16 annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (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. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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V 537	Continued From page 17 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure two of seven staff (the Clinical Director and Psychotherapist) had training in the use of seclusion, physical restraints and isolation time-out training on the use of alternatives to restrictive interventions. The findings are: a. Review on 9/15/21 of the facility's personnel files revealed: - Hire date of 1/13/20. -The Clinical Director had a Nonviolent Crisis Intervention training certificate that expired on 1/14/21. -There was no documentation of current training in the use of seclusion, physical restraints and isolation time-out. b. Review on 9/15/21 of the facility's personnel files revealed: - Hire date of 1/4/21. -The Psychotherapist had no documentation of training in the use of seclusion, physical restraints and isolation time-out Interview with the Executive Director on 9/15/21 revealed: -The agency uses Nonviolent Crisis Intervention training in the use of seclusion, physical restraints and isolation time-out -The therapist and some of the other clinical staff are not required to have training in the use of seclusion, physical restraints and isolation time-out. -It was not a part of their agency policy for clinical staff to get that training. -She confirmed the the Clinical Director and Psychotherapist had no current training in the use	V 537		

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V 537	Continued From page 18 of seclusion, physical restraints and isolation time-out.	V 537		

VERITAS
COLLABORATIVE

October 1, 2021

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

Re: Annual and Complaint Survey completed September 20, 2021

Enclosed, please find the signed Statement of Deficiencies Form with our outlined Plans of Correction for the identified deficiencies, in response to the survey report received on September 23, 2021.

Sincerely,

Sara Hofmeier, Executive Director
Veritas Collaborative, LLC
4024 Stirrup Creek Drive, Durham, NC 27703
shofmeier@veritascollaborative.com

Kristin Surdick, Compliance Manager
888-364-5977, ext. 1637
kristin.surdick@emilyprogram.com