STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1049-098	A. BUILDING: _____ B. WING _____	R-C 07/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 7/29/22. Three of the complaints were substantiated (NC00189508, NC00190168, and NC00190249) and one complaint was unsubstantiated (NC00190308). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 110	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;	V 110	RECEIVED AUG 15 2022 DHSR-MH Licensure Sect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 110	Continued From page 1 (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. 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;	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 110	Continued From page 2 -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.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 114	Continued From page 3	V 114		
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. This Rule is not met as evidenced by: 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.	V 114		

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V 114	Continued From page 4 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.	V 114		
V 367	27G .0604 Incident Reporting Requirements 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 5	V 367		

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

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V 367	Continued From page 6 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. 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)	V 367		

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V 367	Continued From page 7 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.	V 367		

Rockwell Development Center
Balancing Lifes Challenges with Support

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.

Rockwell Development Center
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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.

Rockwell Development Center
Balancing Lifes Challenges with Support

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

Rockwell
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Balancing Lifes Challenges with Support

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.

MA, LCMHC
8/9/2022

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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.

- 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 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 Barbara Perdue at (336) 861-6283.

Sincerely,

Sheri Spicer

Sheri Spicer
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
dhhs@vayahealth.com
Pam Pridgen, Administrative Supervisor