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
	MHL026-892	A. BUILDING: ______ B. WING ______	04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #3	**2299 DOCKWOOD COURT FAYETTEVILLE, NC 28306**

(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 survey was completed on April 3, 2019. The complaint was unsubstantiated (Intake #NC00149905). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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 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	V 367		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 367	Continued From page 1 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;	V 367		

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(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 ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are.

Review on 04/03/19 of the North Carolina Incident Response Improvement System (IRIS) revealed no report from the facility regarding client #1's allegation of sexual abuse.

Review on 04/03/19 of the facility's DHHS (Department of Health and Human Service) Incident and Death Report dated 03/19/19 revealed:
"-On 03/19/19, [Client #1's] treatment team met for his annual ISP (Individual Support Plan) meeting. When [Client #1] care coordinator asked him various questions related to his plan, [Client #1] abruptly stated, 'I'm getting fu**ed in my a**.' [Client #1] then changed the subject. The care coordinator asked the home manager(HM) if [Client #1] had reported this. The HM informed the care coordinator that [Client

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#1] had never reported any incident of anyone, including the staff and [Client #1's] housemate, of touching him inappropriately. HM further explained that [Client #1] and his housemate rarely talk or interact with each other, and that the facility consists of 24-hour awake staff. The care coordinator then moved on and continued with her ISP interview questions. The CEO(Chief Executive Officer)/Director and guardians were notified of [Client #1's] statement."

Review on 04/03/19 of the facility's internal investigation revealed:
"-On 03/19/19 House #3 Home Manager(HM), [HM] notified her supervisor [Qualified Professional (QP)] and myself, [Director] that individual [Client #1] stated during his ISP meeting on 03/19/19 at [MCO] that he was tired of getting f***** in the a**. On 03/19/19 I started an official internal investigation regarding this matter. Prior to starting the investigation, I instructed Home Manager to take [Client #1] to his primary Physician so he can be examined. [HM] stated [Client #1] refused to go to the doctor stating he was fine and did not want to go. During this investigation I spoke to all staff who work in House #3 as well as [Client #1] house mate [Client #2]. I spoke to [HM] who stated during [Client #1's] ISP meeting his care coordinator [Name] asked him what are his likes and dislikes. [Client #1] stated one thing he dislikes is being harassed, [Care Coordinator] asked [Client #1] to giver her more information and he stated, someone is f****** him in the a**, [Client #1] then changed the subject and stated someone stole his blue smurf that he put outside in the garden. [Care Coordinator] then asked her (HM) if [Client #1] has ever mentioned this alleged incident before. [HM] stated [Client #1] has never mentioned anything to her about the

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statement he made. [HM] stated his housemate has never made mention of an incident like this, she further stated [Client #1] and [Client #2] rarely even talk. I spoke to staff [Staff #1] who stated, no one including [Client #1] has ever made mention of this allegation, he also stated house 3 is a 24 hour awake facility, none of the staff have mentioned anything regarding this matter. I spoke to [Staff #4] who stated, he has not seen or heard of any inappropriate acts regarding sexual behaviors. [Staff #4] states the individuals in the home are monitored 24 hours a day to ensure their safety. I spoke to [Staff #2] who stated, he has not seen or heard of any inappropriate sexual acts occurring at house 3. [Staff #2] also stated staff monitors the individuals 24 hours a day to ensure their safety. I spoke to [Client #1's] housemate [Client #2] who stated, he has not touched that man, we don't even talk. I spoke to [Client #1], I asked him about the statement he said during the ISP where he stated someone was f****** him in the a**. He initially said he didn't remember saying it, I asked [Client #1] was anyone getting in bed with him at night and having sex with him, he said I'm not sure. I then asked [Client #1] was his housemate [Client #2] getting into bed with him at night and he replied no, I asked [Client #1] was any of the staff who work at the home getting in bed with him and he replied no. I asked again, so who's getting in your bed at night and he replied no one I guess I was just making it up. I asked [Client #1] was he sure that no one was getting in his bed at night or as he mentioned, f****** him in the a** and he said no one was f****** him in the a** he was just saying that. I asked [Client #1] why would he say something like that and he stated I don't know I was just being silly I guess. In conclusion: After speaking with the staff who work directly with [Client #1] and his house mate [Client #2], I find

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the statement made by [Client #1] to be untrue. Client #1] has a history of making statements regarding things that are sexually inappropriate, seeing and or hearing things that are not there. I explained to [Client #1] that making these types of allegations is very serous and he should tell the truth and not make statements that are not true."

During interview on 04/03/19 client #1 revealed:
-He felt like saying it (sexual acts).
-Nothing was happening to him at night.
-He did not think anything was happening but something may have happened once.
-(client #1 continued to change his story throughout interview and was not consistent with any details).

During interview on 04/03/19 staff #1 revealed:
-He had worked with client #1 as a one to one worker for 5 years.
-Client #1 told care coordinator during an ISP meeting that someone was going into his room at night.
-After the ISP meeting he talked to client #1 and client #1 told him nothing was happening.
-Client #1 was in a very "silly" mood the day of the meeting.
-He was talking about random things the day of the meeting.
-The Director met with me and client #1 after the ISP meeting and client #1 told us what he had said was not true.

During interview on 04/03/19 the HM revealed:
-She was apart of the ISP meeting.
-During the meeting client #1 was having random conversations for example the Care Coordinator asked client #1 where he wanted to live and he stated he wanted to live at the North Pole with Santa.

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V 367	Continued From page 6 -During the meeting he was telling everyone someone stole his blue smurf from the garden. -Client #1 then out of the blue stated he was tired of being "F***** in the a**" but he would not give any details of names or times or when it happened. -After that comment he continued to talk about his smurf being taken and he was tired of it. -She attempted to take client #1 to the doctor to be examined and he refused to go to the doctor. -A internal investigation was completed and a copy was given to DSS (Department of Social Services) for their investigation. -She did not have a level II report but had the report the agency completed.	V 367		