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
	MHL047-136	A. BUILDING: _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #4	332 SOUTH MAIN STREET RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on April 11, 2019. Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27 G .5600C Supervised Living for Adults with Developmental Disabilities	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 responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Lic. & Cert. Section APR 23 2019 DHSR - Mental Health DHSR - Mental Health APR 23 2019 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sarah C. Peel TITLE QP (X6) DATE 4/15/19

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a plan for one of three clients (#1). The findings are: Review on 4/9/19 of client #1's record revealed: -Admission date of 9/19/18. -Diagnoses of Neimann-Pick Type C, Severe Mental Retardation and Seizure Disorder. -There was no documentation of a treatment plan developed for client #1. Interview on 4/9/19 with the Qualified Professional revealed: -Client #1 did not have a treatment plan. -The agency was still waiting on approval of the Innovations Waiver for client #1. -Once the Innovations Waiver was approved client #1 would have a treatment plan. -She did not realize the agency could create a treatment plan until the Innovations Waiver was approved. -She confirmed the facility failed to develop a plan for client #1.	V 112		

Appendix 1-B: Plan of Correction Form

Plan of Correction

Please complete all requested information and email completed Plan of Correction form to:

Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**Serenity Therapeutic Services, Inc.**	**Phone:**	**910-904-7147**
Provider Contact Person for follow-up:	**Mr. Darrin McNeill/ Administrator**	**Fax:**	**910-904-7148**
		Email:	**dmcneill14@nc.rr.com**
Address:	332 South Main Street, Raeford, NC 28376		**Provider # MHL-047-136**

Finding	Corrective Action Steps	Responsible Party	Time Line
V112 27G.0205 (C-D) Assessment and Treatment/Habilitation or Service Plan. 1. The facility failed to develop a treatment plan for one of three clients (Client #1)	QP has developed a service plan of short range goals with Client #1's legal guardian representative to address the individual's habilitative needs as observed by the group home and day program staff, which will be reviewed by the QP as outlined in the plan to determine Client #1's progress. Client #1 is awaiting approval of the Innovations Waiver, therefore, the agency service plan will be updated and/or discontinued and replaced with the official ISP when it is available. QP and the director will ensure that all clients have approved service plans in place.	**Darrin McNeill**	**Implementation Date: April 15, 2019** **Projected Completion Date: April 15, 2019**
			Implementation Date: Projected Completion Date:
			Implementation Date: Projected Completion Date:
			Implementation Date: Projected Completion Date:

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

DHSR - Mental Health
APR 23 2019
Lic. & Cert. Section

April 15, 2019

Darrin McNeill, Director
Serenity Therapeutic Services, Inc.
207 S. Stewart Street
Raeford, NC 28376

Re: Annual Survey Completed April 11, 2019
Serenity Therapeutic Services #4, 332 South Main Street, Raeford, NC 28376
MHL# 047-136
E-mail Address: dmcneill14@nc.rr.com

Dear Mr. Darrin McNeill:

Thank you for the cooperation and courtesy extended during the Annual survey completed April 11, 2019.

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 6/10/19.

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

Cc:
_DHSR_Letters@sandhillscenter.org
DHSR@Alliancebhc.org