STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-148	A. BUILDING: _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #6	10147 ROCKFISH ROAD 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 A complaint survey was completed on August 28, 2019. The complaint was substantiated (Intake #NC00154572). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	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; (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.	V 110		

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V 110	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, facility management failed to assure 1 of 1 former staff (FC #1) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 8/27/19 of Client #1's record revealed: - Admission date of 4/01/19 - Diagnoses of Intellectual Disability; Bipolar Disorder; Traumatic Brain Injury; Unspecified Disruptive, Impulse Control; Conduct Disorder; Major Depressive Disorder; Anxiety Disorder, Unspecified; Insomnia; Psychosis; Extra Pyramidal and Movement Disorder; Urine Incontinence; Gastroesophageal Disease and Asthma. Review on 8/27/19 of Former Staff #1's file revealed: - Hired 10/15/18 as a direct care paraprofessional - Promoted to Lead Staff on 2/25/19 - A signed document regarding employee smoking dated 7/12/19: "Employees are allowed smoke breaks only when required supervision of the individual can be maintained...By signing below, you attest that you understand this policy and will remain compliant while employed by the agency" - Supervisor documented concerns (Disciplinary Actions) related to FS #1's provision of services/supervision to clients on the following dates:	V 110		

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V 110	Continued From page 2 1. 4/8/19 - failed to assist a client in using the bathroom and failed to clean bathroom following client's use 2. 5/2/19 - failed to follow a client's assigned schedule 3. 5/17/19 - asleep on duty 4. 6/21/19 - failed to supervise non-ambulatory client in wheelchair. Client navigated self in wheelchair to another area of building without FC #1 being present to supervise client. 5. 7/26/19 - failed to follow a client's assigned schedule Review on 8/27/19 of the Qualified Professional's (QP) notes revealed the following: - On 7/19/19 Home Manager called QP to report Client #1 "eloped from the facility without staff's knowledge" - "Client #1 was accompanied back to the home by a person driving pass the facility" - QP note dated 7/25/19 documented FS #1 initially reported she had a "feminine emergency" and was using the bathroom when Client #1 responded to auditory hallucinations and left the facility in her wheelchair and rolled into the street. - On 8/1/19, additional information provided by another over-site agency after they reviewed a video of the incident showed FS #1 was on the back porch smoking when Client #1 left the facility in her wheelchair. - FS #1 was removed from the schedule on 8/1/19. - FS #1 was formally terminated on 8/7/19 following the incident with Client #1 for "Failing to perform job duties as outlined; neglecting to ensure the health and safety of the individual." Interview on 8/28/19 with the facility QP confirmed: - FS #1 did not demonstrate the knowledge, skills	V 110		

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V 110	Continued From page 3 and abilities required to provide proper supervision to clients. - FS #1 refused to sign the review and termination form related to her lack of supervision of Client #1.	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the	V 132		

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V 132	Continued From page 4 Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, facility management failed to complete a HCPR report on 1 of 1 Former Staff (FS #1) for neglect. The findings are: Review on 8/27/19 of Former Staff #1's file revealed: - Hired 10/15/18 as a direct care paraprofessional - Promoted to Lead Staff on 2/25/19 Review on 8/27/19 of the Qualified Professional's (QP) notes revealed the following: - On 7/19/19 Client #1 "eloped from the facility without staff's knowledge" - "Client #1 was accompanied back to the home by a person driving pass the facility" - QP note dated 7/25/19 documented FS #1 initially reported she had a "feminine emergency" and was using the bathroom when Client #1 responded to auditory hallucinations and left the facility in her wheelchair and rolled into the street. - On 8/1/19, additional information provided by the local Adult Protection agency after their review of a video of the incident. - The video disclosed FS #1 was on the back porch smoking when Client #1 left the facility in	V 132		

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V 132	Continued From page 5 her wheelchair. - FS #1 was removed from the schedule on 8/1/19. - FS #1 was formally terminated on 8/7/19 following the incident with Client #1 for "Failing to perform job duties as outlined; neglecting to ensure the health and safety of the individual." Review on 8/28/19 of the QP's documentation revealed: - an initial report of the allegation dated 8/5/19 submitted to the Management Care Organization (MCO). - form was resubmitted on 8/20/19 on a form identified as "Complaint Intake and Health Care Personnel Investigations" Review on 8/28/19 of the State's Incident Reporting Information System (IRIS) revealed: - No documentation a HCPR report on FS #1 was found. During interview on 8/28/19, the QP confirmed: - She submitted a report to the MCO - She thought that was all that was required.	V 132		
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	V 367		

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V 367	Continued From page 6 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	V 367		

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V 367	Continued From page 7 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. This Rule is not met as evidenced by: Based on record reviews and interviews, facility management failed to report a level II incident within 72 hours of becoming aware of the incident on a required form. The findings are: Review on 8/27/19 of Former Staff #1's file	V 367		

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V 367	Continued From page 8 revealed: - Hired 10/15/18 as a direct care paraprofessional - Promoted to Lead Staff on 2/25/19 Review on 8/27/19 of the Qualified Professional's (QP) notes revealed the following: - On 7/19/19 Client #1 responded to auditory hallucinations and left the facility in her wheelchair and rolled into the street. - One staff was on the back porch smoking and the other staff was assisting another client when Client #1 left the facility in her wheelchair. - An unknown person driving pass the facility accompanied Client #1 back to the home. Review on 8/28/19 of the QP's documentation revealed: - an initial report of the allegation dated 8/5/19 submitted to the Management Care Organization (MCO). - form was resubmitted on 8/20/19 on a form identified as "Complaint Intake and Health Care Personnel Investigations" Review on 8/28/19 of the State's Incident Reporting Information System (IRIS) revealed: - No report of the incident which occurred on 7/19/19 involving FS #1 rolling her wheelchair into oncoming traffic and staff's failing to properly supervise her. - The report was not submitted on the form provided by the Secretary. During interview on 8/28/19, the QP confirmed: - FS #1 was disciplined however, she continued to work in the facility after the initial internal investigation on 7/22/19. - FS #1 remained on schedule based on the initial staff and client reports. - She was removed from schedule on 8/1/19 after	V 367		

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V 367	Continued From page 9 the facility received the additional information based on the video footage showing FS #1 failed to supervise Client #1. - She submitted a report with the allegation and the internal investigation to the MCO - She thought that was all that was required.	V 367		