Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILBING.			
		MHL036-337	B. WING	····	R 10/03/2019	
NAME OF PROVIDER OR S	UPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE		508 N RA	ANSOM STREET			
OEREMIT HOUSE		GASTON	IIA, NC 28054			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
(V 000) INITIAL C	OMMENTS	:	{V 000}			
2019. De	iciencies w					
category:	10A NCAC Staff Secu	d for the following service 27G .1700 Residential re for Children or				
on July 29 10A NCAG (V105, V1 Requirem .0203 Cor and Assoc 27G .0208 Treatment V112), 10, and Suppi Medicatio V123), Ge Personnel 122C-80 G 10A NCAG General S 24-Hour F Incident R and B Pro Incident R and B Pro Location a referenced (V293) -Ty	and comply, 2019 with 227G .020 06), 10A Nents (V107 petencies iate Profes Assessme (Habilitatio A NCAC 27 ies (V114), a Requirem neral Statu Registry (Variminal Hisc 27G .170 tatute 1220 acility (V36 esponse R viders (V36 eporting Reviders (V36 et acility (V36 et acili	daint survey was completed the following citations: 1 Governing Body Policies CAC 27G .0202 Personnel , V108), 10A NCAC 27G of Qualified Professionals sionals (V109), 10A NCAC ent and nor Service Plan (V111, 10G .0207 Emergency Plans 10A NCAC 27G .0209 ents (V117, V118, V120, te 131E-256 Health Care V131), General Statute story Record Check (V133), 66 Operations (V298), C-62 Additional Rights in a 44), 10A NCAC 27G .0603 equirements for Category A 66), 10A NCAC 27G .0604 equirements for Category A 67), 10A NCAC 27G .0303 Requirements (V736) cross CAC 27G .1701 Scope				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _		_	
	MHL036-337	B. WING		R 10/0	3/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE	508 N RAN	SOM STREET			
JEKENITI 11003E	GASTONIA	A, NC 28054			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{V 000} Continued From page	 : 1	{V 000}			
	ssions was issued to the				
{V 109} 27G .0203 Privileging/	/Training Professionals	{V 109}			
QUALIFIED PROFES ASSOCIATE PROFES (a) There shall be no qualified professionals (b) Qualified professio professionals shall de and abilities required to (c) At such time as a employment system is then qualified professi professionals shall de (d) Competence shall exhibiting core skills ir (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skill (6) communication sl (7) clinical skills. (e) Qualified professio NCAC 27G .0104 (18) met the requirements employment system ir MH/DD/SAS. (f) The governing bod develop and implement for the initiation of an i plan upon hiring each (g) The associate pro	privileging requirements for so or associate professionals. onals and associate emonstrate knowledge, skills by the population served. competency-based is established by rulemaking, ionals and associate emonstrate competence. I be demonstrated by including: dge; ss; Is; kills; and onals as specified in 10 A)(a) are deemed to have of the competency-based in the State Plan for the State Plan for the special professional. of the special professional with the state professional with the				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 2 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		MHL036-337	B. WING		R 10/03/2019
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SERENITY	/ HOUSE		A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{V 109}	Continued From page	2	{V 109}		
	Qualified Professional #8, Qualified Professional Professional/Licensed Professional/Licensed the knowledge, skills, population served. T Review on 9/24/19 of #8's record revealed: -Hire date was 5/8/19 -Job description signe responsibilities includ assistant employees, residential assistant edupdate consumer reciparticipate in peer revimanagement activities Review on 9/24/19 of #9's record revealed: -Hire date of 7/31/19; Job description signe responsibilities includ assistant employees, residential assistant edupdate consumer reciparticipate in peer revimanagement activities Review on 9/24/19 of	and record review, 4 of 4 als (Qualified Professional aional #9, Qualified a #10, and Qualified a #11) failed to demonstrate and abilities required by the a			
	Review on 9/24/19 of	the Qualified e #10's record revealed:			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 3 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		MHL036-337	B. WING		10/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	LIOUSE	508 N RAN	ISOM STREET		
SEKENIII	HOUSE	GASTONIA	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{V 109}	Continued From page	3	{V 109}		
(iss	Review on 9/24/19 of Professional/Licensee -Hire date was 5/8/19 Interview on 9/19/19 a Qualified Professiona	the Qualified e #11's record revealed: . and 9/24/19 with the I #8 revealed:	(* 133)		
	-Responsible for superassistants;-Responsible for treat documentation of services	ment plans and			
		rrent treatment plans did not			
	-Did not realize remove to be included in the o	val of personal items needed client's treatment plan;			
	meetings after Staff #	ff #7 during supervision 7 grabbed Client #4's arm			
	resulting in Client #4	falling off the bed.			
	-It was an oversight th	ne dosages for each recorded on the clients'			
	-Will be more cautious	s with preparing the MARs are the dosages for each			
	-Did not contact Clien fashion to ensure Clie	t #1's physician in a timely ent #1 did not run out of birth			
	control pills; -Did not complete an #4 requested sexual a	incident report when Client			
	-Did not know all incid				
	needed to be complet				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 4 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
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		MHL036-337	B. WING		10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		508 N R	ANSOM STREET		
SERENIT	Y HOUSE	GASTON	NIA, NC 28054		
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{V 109}	Continued From page	e 4	{V 109}		
	(NC IRIS).				
	Interview on 9/24/19 a Qualified Professional Qualified Professional -Responsible for the I clients at the facility; -Worked shifts at the provision of proper call ast Division of Health in July, 2019; -Did not realize that the still did not include streatment without days; -No contact was mad ensure Client #1 wou pills; -There was no attemp physician to discuss a treatment when the p unavailable; -There was a 12-day	al/Licensee #10 and al/Licensee #11 revealed: health and safety of all acility to ensure the are for the clients since the are Service Regulation survey the current treatment plans rategies to address the he clients; birth control pills. There took a few days to get called to the pharmacy. It birth control pills for a few to Client #1's physician to ald not run out of birth control but to contact Client #3's an alternative eczema rescribed ointment was delay in starting Client #3's			
		(treatment of overactive			
	bladder) and a 7-day				
		nt of mood swings) because			
	the facility did not rec	eive a call from the the medications were ready			
		dy from the group home			
		e status of the medications;			
	-Client #4's personal	belongings were removed			
		d stored in the laundry room			
	· •	s to the items because she			
		clothes. Client #4 must			
		her toys. There is nothing nt plan which outlines the			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 5 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74121 2741	or dorate of the transfer of t	IDENTIFICATION NO MIDEN.	A. BUILDING:		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
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{V 109}	will earn time to play to The Licensed Profest active role in providing professionals. This deficiency constitution of the co	belongings or how Client #4 with her toys; sional will take a more g supervision to all qualified itutes a re-cited deficiency. ss referenced into 10 A ope (V293) for a Type A1	{V 109}		
	10A NCAC 27G .0203 TREATMENT/HABILI PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for clien receive services beyon (d) The plan shall incompose (e) achieved by provision projected date of achieved by provision projected date of achieved by a staff responsible; (d) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a service of the plan shall be assessed as a service of the plan shall be assessed	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. clude: I that are anticipated to be a fewement; I view of the plan at least on with the client or legally r both; ion or assessment of			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 6 of 43

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
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SERENITY	/ HOUSE	508 N RA	ANSOM STREET			
02.12.11.1		GASTON	IIA, NC 28054			
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iAG		,	IAG	DEFICIENCY)		
0 / 440)	0 " 15		0/440			
{V 112}	Continued From page	e 6	{V 112}			
	This Rule is not met					
		nd record review, the facility				
	failed to develop and					
	_	the functional needs of the				
	_	clients (Clients #1, #3, and				
	#4). The findings are	:				
	Review on 9/19/19 of	Client #1's record revealed:				
	-Admission date was					
		or Depressive Disorder,				
	Anxiety Disorder, Pos	•				
	Disorder, Oppositiona					
	-16 years old;					
	-History of suicidal ide	eation/behaviors, refusing to				
	attend school, defiand	ce, aggression with peers,				
	assaulting staff, runni	ng away, and sexualized				
	behaviors on a school	•				
	_	acility on 8/30/19 and was				
	located by local law e					
		ool for engaging in sexual				
		peer in a public restroom on				
	a school campus on 9					
		an dated 9/11/19 did not attegies to address running				
		n/behaviors, or sexualized				
	behaviors.	TI/Deliaviors, or sexualized				
	beliaviors.					
	Review on 9/19/19 of	Client #3's record revealed:				
	-Admission date was					
		ntion Deficit Hyperactivity				
		al Defiant Disorder, Major				
	Depressive Disorder;					
	-14 years old;					
		eation/behaviors, difficulty				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 7 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		508 N RA	NSOM STREET		
SERENIT	Y HOUSE	GASTON	IA, NC 28054		
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{V 112}	discomfort, hyperactival rean away from the fallocated by local law electron treatment plainclude treatment strataway. Review on 9/19/19 of reactive Attachment Defiant Disorder, Enural plainclude treatment away. Review on 9/19/19 of reactive Attachment Defiant Disorder, Enural plainclude treatment of the fallocation of the sexuality of the se	expressing feelings of vity, running away; acility on 8/30/19 and was enforcement; an dated 9/5/19 did not ategies to address running Client #4's record revealed: 5/18/19; -Traumatic Stress Disorder, Disorder, Oppositional aresis; and ated 9/11/19 did not ategies to address physical alized behaviors. with the Qualified aled: development of all treatment rrent treatment plans did not address the functional with the Qualified are #10 and Qualified are #11 revealed: current treatment plans still gies to address the	{V 112}		

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 8 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
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		MHL036-337	B. WING		10	/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
SERENIT	Y HOUSE		ANSOM STREET			
			NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
{V 112}	Continued From page	e 8	{V 112}			
	reflect treatment strat functional deficits of e-Will look to hire anot and increase training -The Licensed Profes active role in providin professionals. This deficiency consti	_				
{V 118}	27G .0209 (C) Medica	ation Requirements	{V 118}			
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transfer or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications arecorded immediately MAR is to include the (A) client's name;	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be y after administration. The				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 9 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE	•	
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SERENIT	Y HOUSE		NIA, NC 28054			
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{V 118}	(C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor		{V 118}			
	medications accordin physician affecting 2 #3) and failed to main drugs administered to clients (Clients #1, #2 are: Finding #1 Review on 9/19/19 ar record revealed: -Admission date was -Diagnoses was Majo Anxiety, Post-Trauma Oppositional Defiant I -16 years old; -Physician's order dat (anticonvulsant and tr	ecord review, and ty failed to administer all g to the written order of the of 4 clients (Clients #1 and otain an accurate MAR of all o each client affecting 4 of 4 details, #3, and #4). The findings and 9/24/19 of Client #1's 5/8/19; or Depressive Disorder, or Disorder; and 7/26/19 for Lamotrigine reatment of mood swings)				
	(treatment of anger/ra FE (birth control) 1.5r (treatment of depress	ng 1 tab daily, Propranolol age) 10mg 1 tab daily, Junel ng 1 tab daily, Aripiprazole ion) 5mg 1 tab daily; ted 9/13/19 for Cetirizine				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 10 of 43

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL036-337	B. WING		10/03/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	HOUSE		ISOM STREET			
			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{V 118}	Continued From page	e 10	{V 118}			
	-August, 2019 MAR of Lamotrigine, Bupropri -September, 2019 MA Lamotrigine, Bupropri Aripiprazole, and Cet- -There was no Junel administration on 9/3/ Client #1 not receiving days.	lid not list dosages for ion XL, and Aripiprazole; AR did not list dosages for ion XL, Propranolol, erizine; FE available for /19 and 9/4/19 resulting in g birth control pills for two with Client #1 revealed: re not administered for a few				
	-Lamotrigine 100mg of -Bupropion XL 300mg -Propranolol 10mg disp -Junel FE 1.5mg disp	s medications revealed: dispensed 8/29/19; g dispensed 8/29/19; spensed 8/2919; ensed 9/5/19; te 25mg dispensed 8/29/19;				
	record revealed: -Admission date was -Diagnoses was Oppo Attention Deficit Hype Borderline Intellectua -11 years old; -Physician's order dat (sleep aid) 3mg 1 tab -September, 2019 MA dosage for Melatonin	ositional Defiant Disorder, eractivity Disorder, I Functioning, Asthma; ted 9/18/19 for Melatonin at 7pm; AR incorrectly listed the as 5mg.				
		with Client #2 revealed: prior to going to bed. Could / milligrams of the				

Division of Health Service Regulation

medication she received.

STATE FORM 6899 MDZL12 If continuation sheet 11 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND READ FOR CORRECTION (AS) DATE SUPPLY COMPLETED COMPLETED (COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED (COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED (COMPLETED COMPLETED COMPLE	DIVISION	of Health Service Regu	lation			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE SERENTY HOUSE SUMMAY STATEMENT OF DEPOLENCES PAGE (AACH DEPOCHAN MUST REPECTED BY YOLL). PRICTY (ACH DEPOCHAN MUST REPECTED BY YOLL). PRICTY (ACH DEPOCHAN MUST REPECTED BY YOLL). PRICTY (ACH DEPOCHAN MUST REPECTED BY YOLL). PRICTY (ACH DEPOCHANCE). PRICTY (AS NEED AND MUST REPECTED BY YOLL). PRICTY (ACH DEPOCHAN MUST REPECTED BY YOLL). PRICTY REPOCHANT REP	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOS N RANSON STREET GASTONIA, NC 20054 SUMMARY STATEMENT OF DEFICIENCES OF VILL PREPAR DEPOSITY HOUSE SUMMARY STATEMENT OF DEFICIENCES OF VILL PROVIDERS PLAN OF CORRECTION PREPAR PROVIDERS PLAN OF CORRECTION PREPAR PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PREPAR PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PREPAR PROVIDERS PLAN OF CORRECTION PROVIDERS PROVIDERS PROVIDERS PROVIDERS PLAN OF CORRECTION PROVIDERS PRO	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRIE, ZIP CODE 508 N RANSOM STREET GASTONIA, NC 28054 CAPID PROVIDERS PLAN OF CORRECTION PRICE SUMMARY STATEMENT OF DEPICENCIES PROVIDERS PLAN OF CORRECTION PRICE RECOLUTION OF ALSO IDENTIFYING INFORMATION) (V 118) Continued From page 11 (V 118) Costinued From page 11 Observation on 9/19/19 at approximately 10.55am of Client #25 medications revealed: -Bottle of Melatonia 7mg in the facility. Finding #3 Review on 9/19/19 and 9/24/19 of Client #3's record revealed: -Admission date was 5/23/19; -Diagnoses was Attention Deficit Hyperactivity Disorder, Oppositional Definat Disorder, Major Depressive Disorder; -14 years old: -Physician's order dated 9/19/19 for Singulair (allergy relief) 10mg 1 tab daily; Fluiticasone Propionate (steroid spray to reduce swelling) 50mg 1-2 sprays in both nostitis daily; -September, 2019 MAR did not list dosages for Singulair and Fluicasone Propionatesone Propionate -Interview on 9/25/19 with Client #3 revealed: -Was prescribed a medicated ointment due to the eczema on her neck and arms; -Medicated ointment was never received; -Started using natural soaps and stopped using lotions with perfumes and dyes; -The eczema cleared up without the use of the medicated ointment. Observation on 9/19/19 at approximately 11.00am of Client #3's medications revealed: -Singulair 10mg dispensed 9/19/19; -Fluitcasone Propionate Someg dispensed 9/19/19; -Fluitcasone Propionate Someg dispensed 9/19/19; -Fluitcasone Propionate Someg dispensed 9/19/19; -No Crisaborole ointment available.				-		
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Propionate (steroid spray to reduce swelling) 50mcg 1-2 sprays in both nostrils daily; -September, 2019 MAR did not list dosages for Singulair and Fluticasone Propionate. Interview on 9/25/19 with Client #3 revealed: -Was prescribed a medicated ointment due to the eczema on her neck and arms; -Medicated ointment was never received; -Started using natural soaps and stopped using lotions with perfumes and dyes; -The eczema cleared up without the use of the medicated ointment. Observation on 9/19/19 at approximately 11:00am of Client #3's medications revealed: -Singulair 10mg dispensed 9/19/19; -Fluticasone Propionate 50mcg dispensed 9/19/19; -No Crisaborole ointment available.						
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11:00am of Client #3's medications revealed: -Singulair 10mg dispensed 9/19/19; -Fluticasone Propionate 50mcg dispensed 9/19/19; -No Crisaborole ointment available.			40.4			
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-Fluticasone Propionate 50mcg dispensed 9/19/19; -No Crisaborole ointment available.						
9/19/19; -No Crisaborole ointment available.						
-No Crisaborole ointment available.		-Fluticasone Propiona	ate 50mcg dispensed			
-No Crisaborole ointment available.		9/19/19;				
			nent available.			
Finding #4		Finding #4				

Division of Health Service Regulation

Review on 9/19/19 and 9/24/19 of Client #4's

STATE FORM 6899 MDZL12 If continuation sheet 12 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_B	
		MHL036-337	B. WING		R 10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENIT	Y HOUSE		NSOM STREET			
		GASTONI	A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{V 118}	Continued From page	e 12	{V 118}			
{v 110}	record revealed: -Admission date was -Diagnoses was Post Reactive Attachment Defiant Disorder, Enu10 years old; -Physician's order da Desvenlafaxine (moodaily; -September, 2019 M/ Desvenlafaxine. Observation on 9/24/ of Client #4's medication -Desvenlafaxine 50m Interview on 9/24/19 Professional #9 reveation were not in the medication were not in the medication are docur -Did not contact Client fashion to ensure Client fashion to ensure Client fashion to ensure Client control pills. Interview on 9/24/19 Professional/Licenser -Qualified Profession writing the MARs mode medication related isserted.	5/18/19; -Traumatic Stress Disorder, Disorder, Oppositional aresis; ted 9/18/19 for d regulation) 50mg 1 tab AR did not list dosage for 19 at approximately 9:45am tions revealed: g dispensed 8/21/19. with the Qualified aled: nedication related issues; he dosages for each recorded on the clients' s with preparing the MARs are the dosages for each nented; at #1's physician in a timely ent #1 did not run out of birth with the Qualified er #10 and Qualified er #11 revealed: al #9 was responsible for anthly and overseeing all	{V 110}			
	were no refills left. It another prescription of	took a few days to get called to the pharmacy.				

days;

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 13 of 43

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		MHL036-337	B. WING		10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		508 N RAN	ISOM STREET			
SERENITY HOUSE			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{V 118}	Continued From page	e 13	{V 118}			
	-Client #2 was receiving the correct dose of Melatonin but the dosage recorded on the MAR was incorrect; -Client #3 did not receive the medicated ointment prescribed for eczema because it was on back order from the manufacturer and the pharmacy could not fill the prescription; -There was no attempt to contact Client #3's physician to discuss an alternative eczema treatment; -The Licensed Professional will take a more active role in providing supervision to all qualified professionals. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation.					
{V 123}	and significant advers reported immediately pharmacist. An entry and the drug reaction in the drug record. A shall be charted. This Rule is not met Based on interview at	Drug administration errors see drug reactions shall be to a physician or of the drug administered shall be properly recorded client's refusal of a drug	{V 123}			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 14 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R	
		MHL036-337	B. WING		10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		ANSOM STREET				
GASTON		IIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
{V 123}	Continued From page	e 14	{V 123}			
	or pharmacist affecting The findings are:	ng 1 of 4 clients (Client #1).				
	Review on 9/19/19 ar record revealed: -Admission date was	nd 9/24/19 of Client #1's				
	-Diagnoses was Majo Anxiety, Post-Trauma	or Depressive Disorder, atic Stress Disorder,				
	Oppositional Defiant -16 years old; -Physician's order da	Disorder; ted 7/26/19 for Junel FE				
	(birth control) 1.5mg -There was no Junel	1 tab daily; FE available for				
		/19 and 9/4/19 resulting in g birth control pills for two				
	uays.					
		the facility's Incident rts dated 9/3/19 and 9/4/19 tration of Junel FE to Client				
	#1 due to running out -There was no contact pharmacist document	of medication; ct to a physician or				
		with Client #1 revealed: re not administered for a few ber, 2019.				
	Professional/Licensed Professional/Licensed -Client #1 ran out of b were no refills left. It another prescription of Client #1 went without					
	pharmacist for all med	s made to a physician or dication errors in the future; ssional will take a more				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 15 of 43

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING:			
		MHL036-337	B. WING		10	R / 03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SERENIT	Y HOUSE	508 N RA	NSOM STREET			
		GASTON	IA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
{V 123}	Continued From page	e 15	{V 123}			
	active role in providin professionals.	g supervision to all qualified				
	This deficiency consti	itutes a re-cited deficiency.				
		ss referenced into 10A ope (V293) for a Type A1				
{V 293}	27G .1701 Residentia	al Tx. Child/Adol - Scope	{V 293}			
	children or adolescent free-standing resident intensive, active there interventions within a shall not be the prima who is not a client of (b) Staff secure meat awake during client shall be continuous at this Section. (c) The population seadolescents who have mental illness, emotions substance-related disco-occurring disorder disabilities. These chance the following: (d) The children or an require the following: (1) removal from community-based restacilitate treatment; and (2) treatment in (e) Services shall be	tment staff secure facility for the its is one that is a stall facility that provides apeutic treatment and system of care approach. It may residence of an individual the facility. In staff are required to be deep hours and supervision is set forth in Rule .1704 of the experimental disturbance or corders; and may also have including developmental diddren or adolescents shall inpatient psychiatric services, dolescents served shall may also have including the experimental diddren or adolescents shall inpatient psychiatric services, dolescents served shall in home to a sidential setting in order to a staff secure setting. In designed to: vidualized supervision and				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 16 of 43

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		MHL036-337	B. WING		10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
SERENITY HOUSE		NSOM STREET A, NC 28054				
040.45	CHMMADV CT		<u> </u>	DDOV/DEDIS DI ANI OF CODDECTIO	NI OCT	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
{V 293}	related to functional d (3) ensure safe control behaviors incl management with or (4) assist the cl acquisition of adaptive communication, socia (5) support the gaining the skills need intensive treatment set (f) The residential treshall coordinate with the control of the con	e occurrence of behaviors leficits; ty and deescalate out of uding frequent crisis without physical restraint; nild or adolescent in the e functioning in self-control, all and recreational skills; and child or adolescent in ded to step-down to a less letting.	{V 293}			
	occurrence of behavior deficits, ensure safety control behaviors, assacquisition of adaptive and support the adolenceded to step-down setting and coordinate within the adolescent of 4 clients (Clients # findings are:	•				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 17 of 43

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND FLAIN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	
OFFICIAL	/ UOUOF	508 N RA	NSOM STREET		
SERENIT	Y HOUSE	GASTON	IA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{V 293}	Associate Profession. Based on interview at Qualified Professional #8, Qualified Professional/Licenset Professional/Licenset the knowledge, skills, population served. CROSS REFERENC Assessment and Trea Service Plan (V112) Based on interview at failed to develop and strategies to address client affecting 3 of 4 #4). CROSS REFERENC Medication Requirem Based on interview, robservation, the facili medications accordin physician affecting 1 failed to maintain an a administered to each (Clients #1, #2, #3, a) CROSS REFERENC	alified Professionals and als (V109) and record review, 4 of 4 ls (Qualified Professional conal #9, Qualified e #10, and Qualified e #11) failed to demonstrate and abilities required by the E: 10A NCAC 27G .0205 atment/Habilitation or and record review, the facility implement treatment the functional needs of the clients (Clients #1, #3, and E: 10A NCAC .0209 ents (V118) ecord review, and ty failed to administer all g to the written order of the of 4 clients (Client #1 and accurate MAR of all drugs client affecting 4 of 4 clients nd #4). E: 10A NCAC .0209	{V 293}		
	failed to report medic	ents (V123) and record review, the facility ation errors to the physician g 1 of 4 clients (Client #1).			
	Operations (V298) Based on interview, robservation, the facili	E: 10A NCAC 27G .1706 ecord review, and ty failed to provide access to onal belongings affecting 1			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 18 of 43

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			_
		MHL036-337	B. WING		10	R 9/ 03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OFFICE		508 N RA	ANSOM STREET			
SERENIT	YHOUSE	GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{V 293}	Continued From page	e 18	{V 293}			
	of 4 clients (Client #4).				
	Incident Response Reand B Providers (V36 Based on interview at	nd record review, the facility eir written policies regarding				
	CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) Based on interview and record review, the facility failed to report all Level II incidents to the LME (Local Management Entity) within 72 hours of becoming aware of the incident.					
	-Admission date was -Diagnoses was Post Reactive Attachment Defiant Disorder, Enu -10 years old; -History of physical a others, and sexually v sibling;	-Traumatic Stress Disorder, Disorder, Oppositional Iresis; ggression, threats toward Victimizing her younger				
	with a pencil thrown be threw a water bottle and all and a report dated 9/5/19 upsetting Client #3 are #4's hair and hit her in a report dated 9/10/19	P revealed Client #4 was hit by Client #2 and Client #4 at Client #2; revealed Client #4 was and Client #3 pulled Client				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 19 of 43

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R	
		MHL036-337	B. WING		10/03/2019	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	HOUSE	508 N RAN	ISOM STREET			
GASTONIA		A, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
{V 293}	Continued From page	e 19	{V 293}			
	#4's hair and dragged -Report dated 9/22/19 into Client #2's bedrook belongings and Client bedroom grabbing Client dragging Client #4 off Interview on 9/23/19 v-Client #2 pulled Clier -Staff sit in the living r facility while clients are back of the facility; -No staff sit in the back-When Client #2 threat	I Client #4 on the floor; Prevealed Client #4 went om and took her personal t #2 went into Client #4's ient #4 by the foot and t the bed. with Client #4 revealed: nt #4's hair; room in the front of the re in the bedrooms in the ock of the facility; atens Client #4 and Client #4 f respond with "I don't care;"				
	-Admission date was -Diagnoses was Majo Anxiety Disorder, Pos Disorder, Oppositional -16 years old; -History of sexualized campus; -Suspended from sch relations with a male a school campus on Significant treatment plainclude treatment strain away, suicidal ideation behaviors; -There was no Junel I administration on 9/3/	or Depressive Disorder, st-Traumatic Stress al Defiant Disorder; Il behaviors on a school cool for engaging in sexual peer in a public restroom on 2/3/19; an dated 9/11/19 did not stegies to address running n/behaviors, or sexualized FE available for compared to the stress of the school of the sexual stress of the sexual				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 20 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		D	
		MHL036-337	B. WING		R 10/03/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE	508 N RA	NSOM STREET			
			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{V 293}	Continued From page	e 20	{V 293}			
		ct to a physician or				
		s medications revealed:				
	-No Crisaborole ointment available. Review on 9/19/19 and 9/24/19 of Client #3's record revealed: -Admission date was 5/23/19; -Diagnoses was Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Major Depressive Disorder; -14 years old; -Physician's order dated 8/22/19 for Crisaborole 2% ointment (treatment of dermatitis) twice daily.					
	-Was prescribed a me eczema on her neck -Medicated ointment -Started using natura lotions with perfumes -The eczema cleared medicated ointment.	was never received; I soaps and stopped using				
	record revealed: -Physician's order da	nd 9/24/19 of Client #3's ted 8/22/19 for Oxybutynin f overactive bladder) 5mg 1				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 21 of 43

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			
		MHL036-337	B. WING		R 10/03/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AD		DRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE		NSOM STREET				
		A, NC 28054		T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
{V 293}	Continued From page	21	{V 293}			
	(treatment of mood so daily; -September, 2019 MAChloride and Lamotrig Observation on 9/19/11:00am of Client #3's -Oxybutynin Chloride -Lamotrigine 1mg displanterview on 9/24/19 of #8 revealed: -Did not realize Client supervision."	s medications revealed: 5mg dispensed on 8/26/19;				
	#9 revealed: -Did not realize Client control pills; -Did not realize Client supervision;" -Did not follow up with regarding the eczema unavailable; -Did not know Client and Lamotrigine were one week after the propharmacy. Interview on 9/24/19 and Professional/Licensed Professional/Licensed -Staff have been instrict themselves in the hall clients in the back of the in the front of the facilier.	#4 required "eyes on Client #3's physician cointment being #3's Oxybutynin Chloride enot in the facility for over escriptions were sent to the and 9/25/19 with Qualified e #10 and Qualified e #11 revealed: cucted to position liway so they can observe the facility as well as clients				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 22 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	JE ZIP CODE	1
TO THIS COLUMN	NOVIDEN ON OUT FEEL		SOM STREET		
SERENIT	SERENITY HOUSE GASTONIA				
0/0.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{V 293}	Continued From page	e 22	{V 293}		
	were no refills left. It another prescription of Client #1 went without days; -No contact was made ensure that Client #1 control pills; -Client #3 did not receprescribed for eczema order from the manufacould not fill the prescribed for etzema order from the manufacould not fill the prescribed for eczema order from the manufacould not fill the prescribed for eczema order from the manufacould not fill the prescribed for eczema order from the manufacould not fill the prescribed from the physician to discuss a treatment; -There was a 12-day Oxybutynin Chloride a Lamotrigine because call from the pharmacould from th	ot to contact Client #3's			
	written by the Qualifie	the Plan of Protection ed Professional e Qualified Professional			
	#11/Licensee dated 1	0/3/19 revealed:			
		liately do to correct the			
		in order to protect clients			
		Iditional harm? Describe ure the above happens.			
	Rule Violation Cited:	• •			
		alified Professionals and			
	Associate Professiona				
		nes (Licensee) will interview			
	and hire another Qua	lified Professional with at			
	least 4 years of exper	rience in the group home			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 23 of 43

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MHL036-337	B. WING		10/03/2019	
		WITE030-337			10/03/2019	—
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE		NSOM STREET				
SERENII	HOUSE	GASTON	IIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	_
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	Ξ
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				BEI IOIENOT)		_
{V 293}	Continued From page	23	{V 293}			
	field Dethyrous Croun	Llamas will ansure that				
		Homes will ensure that				
	[Qualified Professional					
	Professional #9] shad					
	Provider]'s Qualified F	<u> </u>				
		ience. Pathways Group				
		[Qualified Professional #8]				
	_	sional #9] monthly to track re that everything is in place.				
	Rule Violation Cited:	, , ,				
	Assessment and Trea					
		differit/i labilitation of				
	Service Plan (V112) Pathways Group Hon	ace will create an				
		ate all new behaviors. An				
	assessment will be co					
		the behavior is determined				
		avior based on the scale				
		cy CFT(Child Family Team)				
	_	o add a goal to the PCP				
		an) for the client to work on				
	II = 1	or. All team members will be				
		hone to inform all members				
	_ ·	sumers behavior/action.				
		10A NCAC 27G. 0209				
		ents (V118) and (V123)				
	_	nes has partnered with				
		ensure a medication needs				
	_	acted Pharmacist] will				
		vill result in staff receiving				
		ied medication technicians.				
	A pharmacy technicia	n has been hired by				
	Pathways Group Hon	ne Directors. The technician				
		n in the home. A form has				
	been created which s	taff will take to every				
	doctor's appointment.	Staff will be required to				
	have this form comple	eted by the doctor before				
	leaving the appointme	ent. The form will have the				
	physician list all curre	nt medication, new				
	medication and disco	ntinued medication. Staff will				

Division of Health Service Regulation

be required to do a pill count and record the number of pills remaining in the bottle after

STATE FORM 6899 MDZL12 If continuation sheet 24 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL036-337	B. WING		R 10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		
OFDENIT	/ UOU0E	508 N RA	NSOM STREET			
SERENIT	HOUSE	GASTON	IA, NC 28054			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	_
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETE	Ī
{V 293}	Continued From page	24	{V 293}			
	medication is given. V	Vhen medication is with in				
		ompleted the Pharmacy				
		t the physician/pharmacy to				
		imer has a prescription on				
		vent a prescription is not on				
		ps will be taken to ensure a				
		ed. A form has been created				
	in which will need to b					
	communication between	en the staff and the				
	provider.					
	Rule Violation Cited:	10A NCAC 27G .1706				
	Operations V298					
		ion, when medication is with				
		completed the Pharmacy				
		t the physician/pharmacy to				
		mer has a prescription on				
		vent a prescription is not on				
		ps will be taken to ensure a				
		ed. A form has been created				
	in which will need to be communication between					
	provider.	cen the stan and the				
	Pathways Group Hom	nes will ensure coordination				
	of care by communication					
	knowledge. A commu					
	created by the Qualifi					
		ation between medical				
		ents. This will be used as				
		ure all client needs have				
		n's management sheet has				
		to document any medication				
	changes. Establishing	bility. We will continue to				
		to team members regarding				
	behaviors, medication					
		y and all incidents that occur				
	in the home.	y and an including that occur				
		nes will ensure a smooth				
		ontinuing to plan at CFT				
	-	p in care for the client.				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 25 of 43

Division of Health Service Regulation

MHL036-337 MAME OF PROMDER OR SUPPLIER SERENITY HOUSE SERENITY HOUSE SUMMARY STATEMENT OF DEFICIENCES FOR Y RANSOM STREET GASTONIA, NO 28084 SUMMARY STATEMENT OF DEFICIENCES FRANCO M STREET GASTONIA, NO 28084 ID PROMDER'S PLAN OF CORRECTION REGULATORY OR LSO IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FROM BY A PROPRIATE (V 293) Continued From page 25 Pathways Group Homes will ensure that all documentation is in chronological order and available for the guardian at the time of transition. In order to ensure that clients' needs are met efficiently, Pathways Group Homes will assess the client and their needs upon admission to determine if additional services may be needed and to create a proactive care plan. If founded, an emergency OFT with be scheduled in order to add the services needed. Pathways Group Homes will support clients in self-care goals by having staff work with them on their person-centered plan goals. Staff will take clients with them to the pharmacy to pick up all medications. At that time, clients will speak with the pharmacist in private with staff present to learn about the medications and what they are utilized for. Pathways Group Homes will promote independent living skills through field trips to job corp. trade schools, independent living programs and college tours. Pathways Group Homes will utilize community resources by continuing the career readiness/college prep program and introducing them to community resources. Rule Violation Cited: 10A NCAC 27G. 3603 and .0604 Incident Response Improvement System within 24 hours. All incidents are reported and entered into IRIS (incident Response Improvement System) within 24 hours. All incidents are reported and entered into IRIS (incident Response Improvement System) within 24 hours. All incidents with be reported to the CIP (Qualified Professionals). The QP will then reported immediately to the directors (Qualified Professionals). The QP will then reported immediately to the directors (Qualified Professionals). The QP will then rep	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER SERENITY HOUSE SUMMARY STATEMENT OF DEPICIENCIES FOR N RANSOM STREET GASTONIA, NC 28054 [CA) D (FA)	ANDILAN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COIVII LI	IILD
SERENTY HOUSE SOURCE SOURCE SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOURCE S						R	ł .
SERENITY HOUSE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAQ SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT			MHL036-337	B. WING		10/0	3/2019
CASTONIA, NC 28054 CASTONIA	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
CASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION CRACK PRODUCTION CRACK PROPRIATE COMPACT CONTINUED PROVIDER'S PLAN OF CORRECTIVE ACTION ADOLD BE CROSS-REFERENCE TO THE APPROPRIATE DATE	CEDENITY	/ HOUSE	508 N RAN	ISOM STREET			
(Y 293) (Y	SERENII	HOUSE	GASTONIA	A, NC 28054			
Pathways Group Homes will ensure that all documentation is in chronological order and available for the guardian at the time of transition. In order to ensure that clients' needs are met efficiently, Pathways Group Homes will assess the client and their needs upon admission to determine if additional services may be needed and to create a proactive care plan. If founded, an emergency CFT with be scheduled in order to add the services needed. Pathways Group Homes will support clients in self-care goals by having staff work with them on their person-centered plan goals. Staff will take clients with them to the pharmacy to pick up all medications. At that time, clients will speak with the pharmacist in private with staff present to learn about the medications and what they are utilized for. Pathways Group Homes will promote independent living skills through field trips to job corp, trade schools, independent living programs and college tours. Pathways Group Homes will utilize community resources by continuing the career readiness/college prep program and introducing them to community resources. Rule Violation Cited: 10A NCAC 27G. 0603 and .0604 Incident Response Requirements for Category A and B Providers (V367) Pathways Group Homes will within 24 hours. All incidents are reported and entered into IRIS (Incident Response Improvement System) within 24 hours. All incidents will be reported to the QP (Qualified Professional). The QP will then reported immediately to the directors (Qualified Professionals).	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
documentation is in chronological order and available for the guardian at the time of transition. In order to ensure that clients' needs are met efficiently, Pathways Group Homes will assess the client and their needs upon admission to determine if additional services may be needed and to create a proactive care plan. If founded, an emergency CFT with be scheduled in order to add the services needed. Pathways Group Homes will support clients in self-care goals by having staff work with them on their person-centered plan goals. Staff will take clients with them to the pharmacy to pick up all medications. At that time, clients will speak with the pharmacist in private with staff present to learn about the medications and what they are utilized for. Pathways Group Homes will promote independent living skills through field trips to job corp, trade schools, independent living programs and college tours. Pathways Group Homes will utilize community resources by continuing the career readiness/college prep program and introducing them to community resources. Rule Violation Cited: 10A NCAC 27G .0603 and .0604 Incident Response Requirements for Category A and B Providers (V367) Pathways Group Homes will ensure that all incidents are reported and entered into IRIS (Incident Response Improvement System) within 24 hours. All incidents will be reported to the QP (Qualified Professionals/Licensees). Staff will document in	{V 293}	Continued From page	e 25	{V 293}			
an incident report. The QP will review all incident reports thoroughly within 24 hours. The directors will review all incident reports within 48 hours. A copy of all incident reports including those	{V 293}	Pathways Group Hondocumentation is in cavailable for the guar In order to ensure that efficiently, Pathways the client and their nedetermine if additional and to create a proace emergency CFT with add the services need Pathways Group Honself-care goals by has their person-centered clients with them to the medications. At that the pharmacist in privilearn about the medicutilized for. Pathways independent living sk corp, trade schools, in and college tours. Pautilize community rescareer readiness/colleintroducing them to conclude Violation Cited: .0604 Incident Response In 24 hours. All incident (Qualified Profession reported immediately Professionals/License the medical record sy an incident report. The reports thoroughly wir will review all incident	chronological order and dian at the time of transition. It clients' needs are met droup Homes will assess beeds upon admission to all services may be needed stive care plan. If founded, an be scheduled in order to ded. In the scheduled in the scheduled in order to ded. In the scheduled in the scheduled in order to ded. In the scheduled in the scheduled in order to ded. In the scheduled in the scheduled in order to ded. In the scheduled in the scheduled in order	{V 293}			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 26 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	F ZIP CODE	10.00.2010
			NSOM STREET	_,	
SERENIT	Y HOUSE	GASTONI	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{V 293}	attend a training on IF MCO (Managed Care Rule Violation Cited: V293 A copy of the state reto the QP and AP (As they can review and use of scope .1700. Pathy partnered with [Local the QP and AP to sha Provider]'s QP to gair understanding of scope. This deficiency constitute a clients range in a were diagnosed with including, but not limit Disorder, Post-Traum Oppositional Defiant ID Deficit Hyperactivity Dintellectual Functionin Disorder, and Cannathad a history of suicid refusing to attend schwith peers, assaulting sexualized behaviors #2 had a history of ph threats towards others suicidal ideation/behamood and expressing hyperactivity, and run history of physical age	ogical order. The QP will RIS when offered by our Organization). 10ANCAC 27G .1701 Scope gulations has been provided sociate Professional) so that understand the requirements ways Group Homes has Level 3 Provider] to allow dow [Local Level 3 n more knowledge and be 1700." tutes a re-cited deficiency. ge from 10 - 16 years and mental health concerns ted to, Major Depressive atic Stress Disorder, Disorder, Anxiety, Attention Disorder, Borderline ug, Reactive Attachment Dis Use Disorder. Client #1	{V 293}		
	The facility did not de individualized treatme				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 27 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		MHL036-337	B. WING		10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE, ZIP CODE	
SERENITY	/ HOUSE	508 N RA	NSOM STREET		
JERENII	I HOUSE	GASTON	IA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
{V 293}	Client #3 ran away. Supervision required least four assaultive of Additionally, the lack required by Client #4 to Client #2 regarding Furthermore, staff depersonal belongings of the current treatment. The facility failed to eadministered on the wand did not ensure the records included medium were nine medication corresponding dosage of care resulted in Clicontrol pills on the salengage in unprotecte Facility staff did not decement treatment or delay in receiving oth Qualified Professional #9, Qualified Professional provide the necessary clients not receiving the deficiency constitutes Type A1 rule violation	n place when Client #1 and Staff did not provide eyes on by Client #4 resulting in at putbursts with peers. of necessary supervision enabled her to write a note provided eyes activity. nied Client #4 access to her which was not identified in plan. Insure all medications were written order of a physician e medication administration lication dosages. There is which did not have ees. Lapses in coordination ent #1 running out of birth me day she chose to	{V 293}		
{V 298}	27G .1706 Residential Operations	al Tx. Child/Adol -	{V 298}		
	10A NCAC 27G .1706 (a) Each facility shall	OPERATIONS serve no more than a total			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 28 of 43

Division of Health Service Regulation

PREFIX TAG TAG		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE SERENTY HOUSE SUMMARY STATEMENT OF DESCIPENCIES FREETY TAG SUMMARY STATEMENT OF DESCIPENCIES SERENTY HOUSE SUMMARY STATEMENT OF DESCIPENCIES FREETY TAG CASTONIA, NC 28054 [EACH OPPROPRIES OF DESCIPENCIES OF TRUE FREETY TAG (V 298) Continued From page 28 (V 298) of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's education plan and the treatment plan. Most of the children will be able to attend school, for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
NAME OF PROVIDER OR SUPPLIER SERENTY HOUSE SUMMARY STATEMENT OF DEFICIENCIES (AC) 10 PREFIX TAG COM 10 PREFIX TAG CROSS-REFERENCED ID THE APPROPRIATE OF 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's educational needs are met as identified in the child's educational needs are met as identified in the child's educational needs are alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th brithday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:							R
SERENTY HOUSE SUMMARY STATEMENT OF DEFICIENCISES DEFICIENCY MUST SEE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX TAG			MHL036-337	B. WING			
CASTONIA.NC 28054 CASTONIA NC 28054	NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
(W4) ID SUMMARY STATEMENT OF DEFICIENCIES REFERX TAG SUMMARY STATEMENT OF DEFICIENCISS (REGULATORY OR ISC DENTIFYING INFORMATION) (V 298) Continued From page 28 of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education gency to ensure that the child's educational needs are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility falled to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:	SERENITY	/ HOUSE	508 N RA	ANSOM STREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (V 298) Continued From page 28 of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's educational needs are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility falled to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:	JEKEMII	111003E	GASTON	IIA, NC 28054			
of 12 children and adolescents. (b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's educational needs are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
(b) Family members or other legally responsible persons shall be involved in development of plans in order to assure a smooth transition to a less restrictive setting. (c) The residential treatment staff secure facility shall coordinate with the local education agency to ensure that the child's education leeds are met as identified in the child's education plan and the treatment plan. Most of the children will be able to attend school; for others, the facility will coordinate services across settings such as alternative learning programs, day treatment, or a job placement. (d) Psychiatric consultation shall be available as needed for each child or adolescent. (e) If an adolescent has his 18th birthday while receiving treatment in the facility, he may remain for six months or until the end of the state fiscal year, whichever is longer. (f) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. (g) Each facility shall operate 24 hours per day, seven days per week, and each day of the year. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:	{V 298}	Continued From page	28	{V 298}			
Based on interview, record review, and observation, the facility failed to provide access to age appropriate personal belongings affecting 1 of 4 clients (Client #4). The findings are:		of 12 children and ad (b) Family members persons shall be invo in order to assure a s restrictive setting. (c) The residential treshall coordinate with to ensure that the chimet as identified in the treatment plan. Mable to attend school; coordinate services a alternative learning proposed placement. (d) Psychiatric consumeded for each child (e) If an adolescent hereeiving treatment in for six months or until year, whichever is lor (f) Each child or adol age-appropriate persentitlement is counterplan. (g) Each facility shall	or other legally responsible lived in development of plans mooth transition to a less reatment staff secure facility the local education agency lid's educational needs are e child's education plan and flost of the children will be for others, the facility will cross settings such as regrams, day treatment, or a set or adolescent. The facility, he may remain the end of the state fiscal ager. The escent shall be entitled to conal belongings unless such reindicated in the treatment operate 24 hours per day,				
Observation on 9/24/19 at approximately 11:25am of Client #4's bedroom revealed:		Based on interview, robservation, the faciliage appropriate person 4 clients (Client #4 Observation on 9/24/	ecord review, and ty failed to provide access to onal belongings affecting 1). The findings are: 19 at approximately				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 29 of 43

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILDING.			
		MHL036-337	B. WING		R 10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENIT	Y HOUSE		NSOM STREET			
			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
{V 298}	Continued From page	e 29	{V 298}			
	-No personal items, to bedroom.	bys, or clothing in the				
	-Admission date was -Diagnoses was Post Reactive Attachment Defiant Disorder, Enu10 years old; -History of physical acothers, and sexually sibling; -Current treatment plato address remove acopersonal belongings. Interview on 9/19/19 acoustic plans and goals; -Did not realize the research	-Traumatic Stress Disorder, Disorder, Oppositional Irresis; ggression, threats toward victimizing her younger an did not include strategies ccess to age appropriate and 9/24/19 with the				
	from her bedroom an to prevent her access had been ripping her -Staff provide one cle wear daily; -Client #4 must earn there is nothing in C which outlines the rer belongings or how Cl with her toys; -The Licensed Profes	e #11 revealed: belongings were removed d stored in the laundry room to the items because she clothes; an outfit for Client #4 to time playing with her toys; Client #4's treatment plan				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 30 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		MHL036-337	B. WING		10	R / 03/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		70072010
			ANSOM STREET			
SERENIT	Y HOUSE	GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{V 298}	Continued From page	e 30	{V 298}			
	This deficiency is cros	tutes a re-cited deficiency. ss referenced into 10A ope (V293) for a Type A1				
{V 366}	implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing measures according to timeframes not to except (4) developing to prevent similar incises (5) assigning por for implementation of preventive measures; (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a) (1) (b) In addition to the Paragraph (a) of this	B INCIDENT REMENTS FOR B PROVIDERS B providers shall develop and icies governing their or III incidents. The policies ider to respond by: The health and safety needs in the incident; The cause of the incident;	{V 366}			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 31 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-337	B. WING		R 10/03/2019
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	10/00/2013
SERENITY HOUSE		SOM STREET		
	GASTONIA	, NC 28054		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{V 366} Continued From page 3	31	{V 366}		
Paragraph (a) of this Ruproviders, excluding ICI develop and implement their response to a leve while the provider is del or while the client is on The policies shall requiriby: (1) immediately siby: (A) obtaining the context (B) making a phone (C) certifying the (D) transferring the review team; (2) convening a more review team within 24 hinternal review team shall composite for with direct professional services at the time of the review team shall composite for with direct professional services at the time of the review team shall composite for the review team.	ule, Category A and B F/MR providers, shall written policies governing Il III incident that occurs livering a billable service the provider's premises. The the provider to respond securing the client record client record; tocopy; copy's completeness; and the copy to an internal meeting of an internal mours of the incident. The all consist of individuals in the incident and who for the client's direct care or oversight of the client's the incident. The internal folte all of the activities as by of the client record to it causes of the incident ations for minimizing the cidents; information needed; preliminary findings of fact is of the incident. The fact shall be sent to the ent area the provider is where the client resides, written report signed by the oths of the incident. The	{v 300}		

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 32 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	5. G5.u.=6G.	152.1111.167.11161.1116.11152.11	A. BUILDING: _		
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
SERENIT	Y HOUSE		NSOM STREET IIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{V 366}	final written report shi identified by the interninclude all public doctincident, and shall maminimizing the occurrall documents needed available within three LME may give the prothree months to subm (3) immediately (A) the LME resarea where the service Rule .0604; (B) the LME which different; (C) the provide for maintaining and utreatment plan, if different; (D) the Departm (E) the client's applicable; and	resides, if different. The all address the issues hal review team, shall uments pertinent to the ake recommendations for ence of future incidents. If d for the report are not months of the incident, the ovider an extension of up to nit the final report; and or notifying the following: ponsible for the catchment ees are provided pursuant to here the client resides, if agency with responsibility podating the client's erent from the reporting	{V 366}		
	failed to implement th	as evidenced by: nd record review, the facility eir written policies regarding el I incidents. The findings			
	-Admission date was	Client #4's record revealed: 5/18/19; -Traumatic Stress Disorder,			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 33 of 43

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.11.2 1 27.11	or connection	IDENTIFICATION NO.	A. BUILDING: _		
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
SERENIT	Y HOUSE		NSOM STREET IA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{V 366}	Defiant Disorder, Enu10 years old; -History of sexually visibling; -Wrote a note to Clier in sexualized behaviorCurrent treatment plate to address sexualized. Review on 9/24/19 of Procedure Manual dares are directly involved, with a complete and the standardized in report shall be completed include all pertinent far persons involved, with damages and method. Interview on 9/24/19 of Professional #9 revearing include and Qualified Professional/Licensed	Disorder, Oppositional presis; ctimizing her younger Int #2 requesting to engage prestogether; and did not include strategies of behaviors. If the facility's Policy and president and to ensure the did care of those individuals are did not includent, then a proper should be incident reporting form. The presence of the end of injury or discontinuous of remedy" With the Qualified aled: incident report when Client activity with Client #2; and Professional/Licensee of the side of the professional #11 regarding the with the Qualified aled: incident report when Client activity with Client #2; and Professional/Licensee of the side of the professional #11 regarding the with the Qualified aled: incident report when Client #2; and Professional/Licensee of the side of the professional #11 regarding the with the Qualified aled: incident report when Client #2; and Professional #11 regarding the with the Qualified aled: incident report when Client #2; and Professional #11 regarding the with the Qualified aled: incident revealed: incident report when Client #2	{V 366}		

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 34 of 43

Division of Health Service Regulation

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		MHL036-337	B. WING		10/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE		SOM STREET		
		GASTONIA	, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{V 366}	Continued From page	e 34	{V 366}		
	active role in providing professionals.	g supervision to all qualified			
	This deficiency consti	tutes a re-cited deficiency.			
	_	es referenced into 10A ope (V293) for a Type A1			
{V 367}	27G .0604 Incident R	eporting Requirements	{V 367}		
	level II incidents, excet the provision of billable consumer is on the princidents and level II of to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the submitted on a for Secretary. The report in person, facsimile of means. The report shinformation: (1) reporting pridentification informat (2) client identification informat (3) type of incidentification of the cause of the incident; (6) other individor responding.	REMENTS FOR B PROVIDERS I providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within reident to the LME tchment area where within 72 hours of le incident. The report shall im provided by the t may be submitted via mail, or encrypted electronic hall include the following lovider contact and lion; fication information; lent; of incident; le effort to determine the			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 35 of 43

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SERENITY HOUSE 508 N RANSOM STREET GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET OF TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING: R 10/03/2019 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET OF TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	STATEMENT OF DEFICIENCIES
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SERENITY HOUSE 508 N RANSOM STREET GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	AND PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SERENITY HOUSE 508 N RANSOM STREET GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 508 N RANSOM STREET GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
SERENITY HOUSE 508 N RANSOM STREET GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
SERENITY HOUSE GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER OR SUPP
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	SERENITY HOUSE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	
DEFICIENCY)	PREFIX (EACH D
{V 367} Continued From page 35 {V 367}	{V 367} Continued Fro
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 unrellable; 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 25C 0.300 and 10A NCAC 27E. Old+(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 III incident;	missing or incomplete shall submit a report recipied day whenever (1) the information progression of the information progression of the required on the information of the required on the information; (2) category upon request obtained regal (1) hose information; (2) report (3) the (d) Category of all level III in the Mental Health Substance Abbecoming away providers shall incidents invoor Health Service becoming away client death wor restraint, the immediately, and the complete shall be complete the catches and the report shall be complete shall be complete the catches and the report shall be complete shall be complete the catches and the report shall be

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 36 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		MHL036-337	B. WING		10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SERENIT	/ HOUSE		ISOM STREET A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
{V 367}	(3) searches of (4) seizures of the possession of a c (5) the total nui incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter (a) and (d) of this Rul through (4) of this Pa	el II or level III incident; i a client or his living area; client property or property in lient; mber of level II and level III ed; and i indicating that there have cidents whenever no red during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1) ragraph.	{V 367}			
	failed to report all Lev (Local Management E becoming aware of the are: Review on 9/19/19 of -Admission date was -Diagnoses was Majo Anxiety Disorder, Pos Disorder, Oppositional -16 years old;	nd record review, the facility yel II incidents to the LME Entity) within 72 hours of the incident. The findings Client #1's record revealed: 5/8/19; for Depressive Disorder, st-Traumatic Stress al Defiant Disorder;				
	Review on 9/19/19 of -Admission date was -Diagnoses was Atter	acility on 8/30/19 and was enforcement. Client #3's record revealed: 5/23/19; ntion Deficit Hyperactivity al Defiant Disorder, Major				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 37 of 43

Division of Health Service Regulation

DIVISION	i Health Service Regu				(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:			
MHL036-337		B. WING		R 10/03/2019		
			1			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SERENITY	'HOUSE	508 N RA	ANSOM STREET			
OLIVLIAITI	HOUGE	GASTON	IIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MATE DATE	
{V 367}	Continued From page	e 37	{V 367}			
	-Ran away from the fa	acility on 8/30/19 and was				
	located by local law e					
	locatou by local law o	and Comone.				
	Review on 9/19/19 of	the facility's Incident				
	Reports revealed:					
	•	rts each dated 8/30/19				
	involving Client #1 and Client #3 running away in					
	separate incidents on 8/30/19; -Each report indicated a report to law enforcement.					
	Interview on 9/24/19 with Qualified Professional					
	#9 revealed:					
	-Was responsible for ensuring completion of the					
	incident reports after each incident; -Did not know that all incidents involving client behaviors resulting in a report to law enforcement					
	needed to be complete					
	(NC IRIS).	sponse Improvement System				
	(NO INIS).					
	Interview on 9/24/19 and 9/25/19 with Qualified Professional/Licensee #10 and Qualified Professional/Licensee #11 revealed: -Will ensure all Level II incidents are completed through NC IRIS in the future; -The Licensed Professional will take a more					
		g supervision to all qualified				
	professionals.					
	This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1					
	rule violation.					
(V 517) 27E .0104(c-d) Client Rights - Sec. Rest. & ITO		{V 517}				
	10A NCAC 27E .0104	SECLUSION,				

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 38 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			7 56.25		R
		MHL036-337	B. WING		10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
SERENIT	Y HOUSE	508 N RA	NSOM STREET		
JEKENII	1 HOUSE	GASTON	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{V 517}	PHYSICAL RESTRA TIME-OUT AND PRO FOR BEHAVIORAL O (c) Restrictive interve employed as a means retaliation by staff or f or due to inadequacy interventions shall no causes harm or abuse (d) In accordance wit 27D, the governing be delineates the permis interventions within a	INT AND ISOLATION OTECTIVE DEVICES USED CONTROL entions shall not be s of coercion, punishment or for the convenience of staff of staffing. Restrictive t be used in a manner that e. th Rule .0101 of Subchapter ody shall have policy that sible use of restrictive facility.	{V 517}		
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure restrictive interventions were not employed as a means of punishment, retaliation by staff, or a manner that causes harm or abuse affecting 1 of 4 clients (Client #4). The findings are:				
	-Admission date was -Diagnoses was Post Reactive Attachment Defiant Disorder, Enu -10 years old; -History of physical ag others, and sexually v sibling; -Assessment dated 7, requires "eyes on sup Review on 9/24/19 of -Hire dated of 5/26/19 -Employed as Reside	-Traumatic Stress Disorder, Disorder, Oppositional resis; ggression, threats toward victimizing her younger /29/19 revealed Client #4 pervision." Staff #7's record revealed:			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 39 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
	MHL036-337	B. WING		R 10/03/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SEDENITY HOUSE	508 N RA	NSOM STREET		
SERENITY HOUSE	GASTON	IA, NC 28054		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
daily/community living documentationdem agency policies and prindividual safety needs significant changes in quality customer serveral properties of the	with daily activities eventions to build or management skills, and g skillsmaintains constrates knowledge of proceduresresponds to dis, including reporting to behaviorprovides high ice;" Be Based Protective on 7/1/19, with re-training on disciplinary warning for 1 for using a restrictive ans that caused harm; The facility's Incident 19/12/19 completed by Staff ent with Client #4 revealed: sed that she had to pass all. Staff caught her coming room when she saw staff thee. Staff said no, she then the bed staff went to grab her oldconsumer fell off bed go back in dining room after the staff room. Staff went to ther out of her room tay out of consumers room. It #4] stay in her room."	{V 517}		

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 40 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	DF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
		MHL036-337	B. WING		R 10/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENIT	/ HOUSE		NSOM STREET		
	QUILLEN OT		A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{V 517}	Continued From page	e 40	{V 517}		
	on the proper use of incident when Staff #	al #8 never had a discussion restraint interventions or the 7 intervened with Client #4 ulting in Client #4 falling off			
	-Had been put in a ph the past few days and arms behind her back -Staff #7 hurt Client # and by putting Client -Staff #7 told Client #	with Client #4 revealed: hysical restraint by Staff #7 in d Staff #7 bent Client #4's k; d by pulling Client #4's arms #4's arms behind her back; 4 not to tell anyone because another fine by the State.			
	Attempted interview on 9/25/19 with Staff #7 was unsuccessful. The telephone recording revealed the mailbox was full and no further messages could be accepted.				
	Professional/Licensed Professional/Licensed -Staff #7 requested to position to a PRN (as 9/16/19; -Staff #7 wanted the deffective 10/1/19; -Staff #7's last day of 9/20/19; -Staff #7 would no lor as of 9/24/19 due to definite actions; -The Licensed Professional	e #11 revealed: o move from a full-time needed) position on change in employment to be work at the facility was			
	written by the Qualifie	the Plan of Protection ed Professional Qualified Professional			

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 41 of 43

Division of Health Service Regulation

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL036-337		B. WING		R 10/03/2019	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	10.00.2010	
SERENITY	/ HOUSE		SOM STREET			
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	, NC 28054	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{V 517}	Continued From page	e 41	{V 517}			
	#11/Licensee dated 1 "What will you immed above rule violations from further risk or ad your plans to make supathways Group Homes will hole policies and procedur. This deficiency constitution of the policies and procedur. This deficiency constitution of the policies and procedur. Client #4 is 10 years and procedur. Client #4 is 10 years and procedur. Disorder. She has a an an an an angression, threats to victimizing her young. Client #4 by the foot the bedroom causing Client with the policient and behind her bareceived disciplinary and interventions which can ont independently received. This deficiency correct the Type A1 refor serious abuse. Ar	0/3/19 revealed: iately do to correct the in order to protect clients ditional harm? Describe ure the above happens. nes (Licensee) has as of 9/25/2019. Pathways d a staff meeting to reiterate es with all remaining staff." tutes a re-cited deficiency. old and is diagnosed with s Disorder, Reactive and Oppositional Defiant				
{V 736}	27G .0303(c) Facility	and Grounds Maintenance	{V 736}			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.					

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 42 of 43

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						R	
		MHL036-337	B. WING		10	/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	FE, ZIP CODE			
SERENITY	HOUSE		NSOM STREET IA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
{V 736}	Continued From page	: 42	{V 736}				
	was not maintained in attractive manner. The Observation on 9/24/11:25am revealed: -Client #4's bedframe mattress and box spri-Sheet covering the ri-Client #2's bedroom Interview on 9/24/19 and Professional/Licenseed Professiona	and observation, the facility in a clean, safe, and the findings are: 19 at approximately was broken, and the ling was on the floor; ght window of the bedroom; door did not latch. and 9/25/19 Qualified the #10 and Qualified the #11 revealed: If the result is the floor in th					

Division of Health Service Regulation

STATE FORM 6899 MDZL12 If continuation sheet 43 of 43