PRINTED: 11/26/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED							
		MHL026-892	B. WING			R 2 2/2019						
NAME OF F	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	STATE. ZIP CODE	,							
SERENITY THERAPEUTIC SERVICES #3 2299 DOCKWOOD COURT												
FAYETTEVILLE, NC 28306												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 THE APPROPRIATE	(X5) COMPLETE DATE						
V 000	INITIAL COMMENTS		V 000									
		w up survey was completed 019. A deficiency was cited										
	category: 10A NCA	sed for the following service AC 27G .5600C Supervised h Developmental Disabilitie										
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114									
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaste shall be held at least repeated for each sunder conditions the	n for each facility and plan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be conducted to all staff cedures and routes shall be shift. Drills shall be conducted at simulate fire emergencies all have basic first aid supplies.	ed s.									
	facility failed to hold	et as evidenced by: views and interviews, the I fire and disaster drills at le ted on each shift. The	ast									
	Professional (QP) s follows: -Monday - Friday:	v on 11/15/19 the Qualified stated the facility shifts were 1st shift, 8 am - 4 pm; 2nd night; 3rd shift, 12 midnight										

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

(X6) DATE TITLE

PRINTED: 11/26/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	` ´oone	(X3) DATE SURVEY COMPLETED								
THE PERIOD CONNECTION	BENTH 16/1/16/1/NOMBER.	A. BUILDING:										
	MHL026-892	B. WING	R 11/22/2	2019								
NAME OF PROVIDER OR SUPP	LIER STREET A	DRESS, CITY, STATE, ZIP CODE										
SERENITY THERAPEUTIC SERVICES #3 2299 DOCKWOOD COURT FAYETTEVILLE, NC 28306												
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)									
Review on 11/7/1/18 - 9/30/1 -Quarter 1/1/1 documented for -Quarter 7/1/1 documented for end 8 pm - 8 and 9 pm -	ts: 8 am - 8 pm, and 8 pm - 8 am. 5/19 of the fire drills between 7 revealed: 1 - 3/31/19: No fire drills 1 - 9/30/19: No fire drills 1 - 10 the week end 8 pm - 8 am shift. 2 - 9/30/19: No fire drills 2 r the week day 3rd shift or week 3 shift. 5/19 of disaster drills between 6 revealed: 8 - 12/31/18: No disaster drills 1 r the week day 1st shift or week 1 shift. 1 - 3/31/19: No disaster drills 1 r the week day 2nd shift and week 1 m. 2 - 6/30/19: No disaster drills 1 r the week day 3rd shift or the 2 8 pm shift. 3 9 m shift. 4 8 pm shift. 5 1 8 pm shift. 6 9 cheduled each month with 7 1 1 1 2 - 8 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	V 114										

Division of Health Service Regulation

STATE FORM 9V7V11 If continuation sheet 2 of 3

PRINTED: 11/26/2019 FORM APPROVED

Division of Health Service Regulation

	A. DOILDING.		(X3) DATE SURVEY COMPLETED								
			R								
MHL026-892	B. WING			2/2019							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
SERENITY THERAPEUTIC SERVICES #3 2299 DOCKWOOD COURT FAYETTEVILLE, NC 28306											
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE							
V 114 Continued From page 2	V 114										
medical emergency, and ozone alert.											
Interview on 11/15/19 client #2 stated: -They only did fire drillsThey may have done something like a tornado drill and he had forgottenThey would go outside for the fire drills. Interview on 11/15/19 client #1 stated they did fire drills. Client #1 did not identify any disaster drills were done. Interview on 11/15/19 Staff #2 stated: -The facility was provided a schedule for fire drills and disaster drillsStaff held fire and disaster drills according to the scheduleShe had worked at the facility for 4 months and had not done a disaster drill.											

Division of Health Service Regulation STATE FORM

9V7V11 If continuation sheet 3 of 3