

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on April 16, 2020. The complaint was unsubstantiated (intake #NC00162318). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision</p>	V 109		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 1</p> <p>plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professional (QP) audited failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 4/13/2020 of the Qualified Professional's (QP) personnel record information revealed she was hired 5/12/2010.</p> <p>Review on 4/9/2020 and 4/13/2020 of client #5's record revealed: -42 year old male admitted 11/22/19. -Diagnoses included bipolar with severe psychotic features; intermittent explosive disorder; mild intellectual and developmental disabilities; borderline diabetic; hypertension; acid reflux; and, chronic obstructive pulmonary disease. -Admission Assessment, signed/dated by the QP 11/23/19, documented client #5 had been an "emergency placement" due to issues with his previous group home provider that required him to leave within 10 days. He had a long history of mood disturbance and had a very difficult period within the prior 5 months at his previous group home. He had become aggressive with staff, voiced suicidal ideations, and engaged in severe property damage in the group home. Client #5</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 2</p> <p>was not a "morning person" and was easily agitated. Being authoritative or telling client #5 what to do when he was upset was proven to be unsuccessful. Behaviors were caused by not smoking, not wanting to wake up in the mornings, being treated in an authoritative way, or in a way client #5 felt was rude and disrespectful.</p> <p>-Client #5's Individual Service Plan and Short Term Goals dated 3/1/2020 documented 1 short term residential goal that addressed aggressive behavior and read, "[Client #5] positively communicates his wants and needs with staff at the group home, Day Program, and in the community as needed with no more than 3 verbal prompts per occasion for 6 consecutive months... [Client #5] will not become angry or aggressive when he has trouble expressing himself." Staff actions included, if client #5 became upset, staff would give him space to calm down before revisiting the issue being sure to provide continuous monitoring for his safety.</p> <p>-There were no goals or strategies that addressed smoking behavior or a smoking schedule, or that addressed his needs specific to early morning tendencies to become easily agitated.</p> <p>Review on 3/30/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility in March 2020 revealed:</p> <p>-One level II IRIS report for a restrictive intervention of client #5 by Former Staff (FS) #15 at 6 am on 3/18/2020. The report did not include client #5's injury, a lip laceration.</p> <p>-No level II IRIS reports for restrictive interventions on 3/22/2020, both associated with smoking behaviors.</p> <p>-No level III IRIS report for an allegation of abuse on 3/18/2020.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 3</p> <p>Interview on 4/9/2020 client #5's Guardian stated: -Client #5 called her at 4 pm on 3/18/2020 and told her he was in a lot of pain and hurting. When she asked him why he was in pain he told her the staff punched him in the face, that he had a mouth full of blood, and his stomach hurt, in his words, "like a son of a gun." (Staff was Former Staff (FS) #15) She asked if he had told the staff and he said, "no." -She called the QP and was told she knew nothing of the situation. -3/18/2020 was the only time she was aware client #5 had been put in a restraint. She had not been notified of any subsequent restraints. -The facility was to notify her every time client #5 was put into a therapeutic hold or restraint.</p> <p>Interview on 4/7/2020 and 4/9/2020 the QP stated: -She learned of an allegation of abuse made by client #5 against FS #15 on 3/18/2020. An IRIS report had been submitted. -The QP had reported this allegation to the Health Care Personnel Registry (HCPR) and the Department of Social Services. She would provide documentation of the HCPR reporting. -There was an internal incident report for a restrictive intervention on 3/22/2020.</p> <p>Interview on 4/16/2020 the HCPR Investigator stated the initial and the final investigation reports for an allegation of abuse made by client #5 against FS #15, received by the facility on 3/18/2020, had been received by the HCPR on 3/23/2020.</p> <p>Refer to V112 for the failure to develop and implement strategies to address client #5's behaviors; V318 for the failure to report to the HCPR within 24 hours; V366 and V367 for</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 4 failures to respond and report Level II and Level III incidents. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 2 of 3 paraprofessional staff audited (Lead Staff, Group Home Manager) and 1 of 1 former staff audited (Former Staff (FS) #15) failed to demonstrate knowledge, skills, and abilities required by the population served. The findings are:</p> <p>Review on 4/13/2020 of the Lead Staff's personnel information revealed: -Date of hire: 5/26/19 -Position: Lead Staff -EBPI (Evidence Based Protective Interventions) - Base completed 6/12/19.</p> <p>Review on 4/13/2020 of the Group Home Manager's personnel information revealed: -Date of hire: 10/6/2014. -EBPI - Base completed 7/18/19.</p> <p>Review on 4/8/2020 of FS #15's personnel information revealed: -Date of hire: 2/26/18. -Involuntary Termination date: 3/30/2020 -Position: Paraprofessional -Reason for termination: Allegation of abuse -EBPI - Base completed 3/5/19; expiration 3/31/2020.</p> <p>Review on 4/8/2020 of Staff #3's written statement dated 3/19/2020 revealed: -When he arrived to work at 6:40 am on 3/18/2020 client #5 was sitting in the office with a coat over his head.</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 6</p> <p>-"While [Lead Staff] and [FS #15] was telling me whats just happen I then received a call from Home Manager also giving me a run down of what she expected. [Client #5] then requested to speak to her, so they talk... I observed [client #5's] lip and asked him to rinse his mouth out..."</p> <p>Review on 4/8/2020 of Staff #10's written statement dated 3/19/2020 revealed: -Staff #10 arrived to work on 3/18/2020 at 6:45 am. -Client #5 was sitting in the office with a mouth full of blood, face red, and he was crying. -FS #15 was at the medicine cabinet trying to give other clients' medications.</p> <p>Review on 4/8/2020 of the Lead Staff's written statement dated 3/19/2020 revealed: -"When I arrived at the facility, Individual (client #5) was on the floor kicking, spitting and screaming at staff calling staff names and talking about staff mother. Staff and I tried to calm down individual (client #5) asking him to use his breathing techniques. Staff asked individual (client #5) if he wanted to go to his room. Individual (client #5) said he want to sit in the office with Staff. Staff agreed and Individual(client #5) sat in the office with Staff. Lead Staff processed with the other shift about the situation at hand."</p> <p>Review on 4/8/2020 of FS #15's written statement (undated) revealed: -"On March 18 th around 6 am staff was handing out meds (medications) when individual (client #5) was trying to go outside with a tank top and shorts, staff then redirected individual to go put on proper clothes so he can go outside. Individual then called staff racist names and said staff's mother is a "B." Individual then ran to front</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 7</p> <p>door and staff got in front of him. Individual began swinging and staff put individual in therapeutic hold then individual fell down on ground and while on ground another individual (client #1) began attacking [client #5], so staff redirected other individual and began calming [client #5] down. Individual then began to cry and apologizing to staff. Staff let individual stay in med room to calm down when other staff arrived to facility. Lead Staff was present when staff was getting individual off the ground."</p> <p>Interview on 4/13/2020 Staff #10 stated: -She worked the day shift on 3/18/2020. She had started working there on 3/16/2020. She had never worked in a group home before. -When she arrived on 3/18/2020, the Lead Staff was exiting the home. He walked to her car and told her there had been an incident. -When she went inside client #5 was sitting in a chair near the door, crying, and was talking on the phone. His mouth was bloody.</p> <p>Interview on 4/7/2020 Staff #3 stated: -When he reported to work on 3/18/2020, he saw client #5 sitting in a chair with a bloody lip. He could not see where the blood was coming from. The blood was dried. His lip was not swollen. -He administered first aid, cleaned the area and applied Neosporin (antibiotic ointment). Client #5 did not complain of pain.</p> <p>Interview on 4/9/2020 client #5's Guardian stated: -Client #5 called her at 4 pm on 3/18/2020 and told her he was in a lot of pain and hurting because the staff (FS #15) punched him in the face, that he had a mouth full of blood, and his stomach hurt. She asked if he had told the staff and he said, "no." -After talking with client #5 on the phone, she</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 8</p> <p>spoke to the Lead Staff and was told he (Lead Staff) had come into work that morning and client #5 was in a "full on rage," and had been "contained" when he got to him. She called the Qualified Professional (QP) and was told the QP knew nothing about the situation and would need to gather some information.</p> <p>-She was concerned that 3 staff saw client #5 with blood coming from his mouth and not one staff reported the incident or got client #5 any help until client #5 called her at 4 pm.</p> <p>Interviews on 4/7/2020 and 4/13/2020 the Lead Staff stated:</p> <p>-On the morning of 3/18/2020 he went to the facility to deliver keys to FS #15.</p> <p>-When he walked in FS #15 and client #5 were on the floor in the hall. Client #5 was spitting on FS #15 and name calling.</p> <p>-Client #5 had blood on his mouth. His lip was not swollen.</p> <p>-The Lead Staff did not look at client #5's lip to see if he had a cut. He thought FS #15 assessed the client's injury.</p> <p>-Before the Lead Staff left the facility, he called the Group Home Manager and she talked with client #5 on the phone.</p> <p>-He left the facility when the day shift staff arrived.</p> <p>Interview on 4/13/2020 the Group Home Manager stated:</p> <p>-The Lead Staff called her the morning of 3/18/2020 and told her client #5 "had a behavior."</p> <p>-She was not informed there had been a therapeutic hold or that the client was injured.</p> <p>-When client #5 had a behavior it was typically using profanity.</p> <p>-She did not recall speaking with client #5 on the phone 3/18/2020.</p> <p>-She called back to the facility and talked with</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 9</p> <p>Staff #3 to tell him to monitor client #5 because of his behaviors earlier that morning.</p> <p>-She learned of the therapeutic hold after client #5's guardian called the QP later that afternoon. She went to the facility, interviewed staff and client #1, and had them to write statements. At first client #5 refused to go to the emergency room, but after talking with her, he agreed and was taken around 6 pm -7 pm on 3/18/2020.</p> <p>-When asked if any other actions had been taken with staff as a result of this incident, she responded that FS #15 and all staff had EBPI.</p> <p>Interview on 4/13/2020 FS #15 stated:</p> <p>-He had worked at the facility for 2 years and was terminated 1-2 weeks prior.</p> <p>-On his last day, (3/18/2020) client #5 was trying to go outside around 5:30 am - 6 am. Client #5 was wearing only a tank top and his night shorts, and no shoes. FS #15 told client #5 he could not go out because of the Corona virus and he needed to put on some pants.</p> <p>-Client #5 became irate and started calling him the "N" word. FS #15 was giving the morning medications. Client #5 tried to run outside, and FS #15 stood in front of the door. Client #5 grabbed FS #15 with one hand and started hitting the staff with his other hand. FS #15 tried to put client #5 into a therapeutic hold. Client #5 was biting FS #15's fingers. They both fell to the floor. The client weighed about 300 pounds. This happened in the facility hallway.</p> <p>-FS #15 had told the other clients to go to their rooms when client #5 first became "irate."</p> <p>-When FS #15 and client #5 fell, client #1 came out of her room and started hitting client #5 with a shirt, then kicked him twice in the head and client #5's head hit the floor. FS #15, using his forearm, pushed himself up off the client using his body weight. He then got client #1 back in her</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 10</p> <p>room. Client #5 was "tired out," he was "breathing hard," and he started making verbal threats that he would get FS #15 fired.</p> <p>-About 5 minutes later the Lead Staff and the day shift staff all arrived within a few minutes of each other. Client #5 was sitting in the office talking with FS #15.</p> <p>-When asked if client #5 was assessed for injuries, FS #15 stated the client had "a little blood on his lip." He started bleeding when client #1 kicked him.</p> <p>-When asked if he called his manager or the QP following the 3/18/2020 incident, FS #15 stated he did not because he told the Lead Staff what had happened. The Lead Staff was "like an assistant manager." The Lead Staff talked to client #1 and client #5 and called the manager.</p> <p>-Asked if the Lead Staff did a debrief with him about the therapeutic hold, FS #15 stated there was no discussion. All that the Lead Staff instructed him to do was document an incident report, which he completed before he clocked out.</p> <p>Interview on 4/7/2020 the QP stated: -She was called by client #5's guardian around 4:25 pm on 3/18/2020 and made aware client #5 made an allegation against FS #15. -This was the first she heard of an incident that occurred between client #5 and FS #15 on 3/18/2020.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.</p>	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 11</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to develop and implement treatment plan strategies to prevent and/or respond to aggressive behaviors for 1 of 1 clients audited. (client #5). The findings are:</p> <p>Review on 4/9/20 and 4/13/20 of client #5's record revealed:</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 12</p> <p>-42 year old male admitted 11/22/19. -Diagnoses included bipolar with severe psychotic features; intermittent explosive disorder; mild intellectual and developmental disabilities; borderline diabetic; hypertension; acid reflux; and, chronic obstructive pulmonary disease. -Hospitalized 3/23/2020 - 3/31/2020. Discharge diagnosis was schizoaffective disorder, bipolar type.</p> <p>Review on 4/9/2020 of client #5's Admission Assessment dated 11/23/19 revealed: -Client #5's care coordinator "reached out" seeking emergency placement due to issues with his previous group home provider that required him to leave within 10 days. The care coordinator shared "vital information" in regards to his need for placement. He had a long history of mood disturbance and had a very difficult period within the last 5 months at his previous group home. He had involuntary commitments (IVC) in July, August, and November 2019. He had become aggressive with staff, voiced suicidal ideations, and engaged in severe property damage in the group home. His relationship with staff needed to be therapeutic, not authoritative. -He was not a "morning person" and was easily agitated when rushed. It was best to use a neutral tone of voice in the morning hours. -"What does a crisis look Like? Physical aggression, destruction of property, elopement, profanity and IVC's for periods of time." -"What proves to be unsuccessful with a crisis? Being Authoritative attempting to tell [client #5] what he needs to do when he was upset" -"What causes a behavior? Not smoking, not wanting to wake up in the mornings, being demanding (Authoritative) and when he is addressed in a way [client #5] feels is rude and disrespectful."</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 13</p> <p>Review on 4/9/2020 and 4/16/2020 of client #5's Individual Service Plan and Short Term Goals dated 3/1/2020 revealed:</p> <ul style="list-style-type: none"> -He had maintained higher than optimal body weight at 6 feet tall and 278 pounds. -He had started to smoke after a long break from the habit. -Behavioral health support needs: In the year prior to admission, client #5 had several IVC's and many visits to the Emergency Department for ideations of self-harm and fighting with peers and staff. Relationship with staff needed to be therapeutic not authoritative. He had been linked with specialized consultation services and a behavior plan was being formulated. -"Things that may create stress. Situations where I'll need extra help," documented client #5 was not a "morning person" and was easily agitated when rushed. -"How to Support Me Best," documented if client #5 became non-compliant and showed physical aggression, he liked to talk about his feelings after he had calmed down. "Try to give [client #5] the opportunity to have a conversation with the clinical director or QP (qualified professional) as this has worked to de-escalate him in the past." -"Crisis Planning What a Crisis Looks Like for Me? When [client #5] does not feel well he tends to present with a behavior if the issue is not addressed quickly. [Client #5] is known to reminisce on past negative events or stressors and obsess about what has been promised to him but has not happened yet. [Client #5] lacks patience and lives in the moment so what is promised to him in the future should be available today. Lack of staffing could cause [client #5] a crisis. [Client #5] likes attention and is very impatient. If there is not enough staff on duty [client #5] will usually take matters in to his own 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 14</p> <p>hands. [Client #5] can become overly stimulated in crowds."</p> <p>-1 short term goal addressed aggressive behavior and read, "[Client #5] positively communicates his wants and needs with staff at the group home, Day Program, and in the community as needed with no more than 3 verbal prompts per occasion for 6 consecutive months... [Client #5] will not become angry or aggressive when he has trouble expressing himself." Staff actions included, if client #5 became upset, staff would give him space to calm down before revisiting the issue being sure to provide continuous monitoring for his safety.</p> <p>-There were no goals or strategies that addressed smoking behavior or a smoking schedule, or that addressed his needs specific to early morning tendencies to become easily agitated.</p> <p>Review on 3/30/2020 of client #5's North Carolina Incident Response Improvement System (IRIS) report of a level 2 incident, restrictive intervention, on 3/18/2020 revealed:</p> <p>-At 6 am Former Staff (FS) #15 observed client #5 attempting to go outside wearing only a tank top and shorts, which were not weather appropriate. The staff verbally redirected client #5 to return to his room to put on warmer clothing, i.e. a coat, as it was cold outdoors. [Client #5] became verbally aggressive, calling FS #15 derogatory names and telling staff "get the F*&% out of his face."</p> <p>-The client went into his room, "slamming his door and retrieved his coat and proceeded to go outside." FS #15 asked the client to give him time to check on the other clients to make sure they were "ok" so he could monitor client #5 while outdoors. Client #5 became physically aggressive, and tried to hit the staff. FS #15</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 15</p> <p>placed client #5 in a therapeutic wrap.</p> <p>Review on 4/8/2020 of facility incident reports dated 3/22/2020 revealed: -At 2 pm on 3/22/2020 client #5 woke up and requested his "12:00" cigarette. "[Staff #3] prompted [client #5] that we have to stick to his schedule and told him he missed his 12 but he will be able to get his 4:00 when it's time." Client #5 became verbally and physically aggressive toward Staff #3 and was placed in a therapeutic hold. As Staff #3 released him from the hold, client #5 bite down on the staff's fingers and did not let go until the staff promised him a cigarette. -At 3:45 pm on 3/22/2020 Staff #3 realized client #5 had moved from the porch to an area near the back gate out of the staff's sight. Staff #3 asked client #5 to return to the porch, and noticed the client was smoking cigarette butts from an ashtray. The staff went to dump the ashtray and client #5 "began attempting to fight staff and threatening to harm himself." Staff placed client #5 in therapeutic hold.</p> <p>Review on 4/16/2020 of the Department of Social Services Adult Protective Services Social Worker (DSS-APS-SW) summary dated 3/20/2020 revealed: -The DSS-APS-SW interviewed client #5 on 3/20/2020. -"... Adult (client #5) stated that 2 days ago he was trying to go outside and get fresh air and while he was going the staff member grabbed him from behind. He stated that he told him 3 times to stop grabbing him from behind, but he continued, and adult stated at that point he swung. He stated that the staff member then slammed him down on the ground and then began punching him in the face and stomach and resident kicked him. He stated that he does not</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 16</p> <p>know that staff members name. SW observed adult's lip which appears to be healing from a busted lip. Adult stated that he told his guardian what happen but could not tell SW who his guardian was."</p> <p>Review on 4/15/2020 of client #1's statement revealed: -"[Client #5] wanted to go outside. Staff [FS #15] said yes you could go outside once you put a jacket on because it's cold outside. [Client #5] then started walking down the hallway. While [client #5] was walking down the hallway he was using very bad language. [FS #15] told [client #5] to stop using that kind of language if not you will not go outside. [Client #5] wouldn't stop so [FS #15] said now you have to wait until i'm done giving meds. so I could go outside with you. [Client #5] continue to go out the front door not caring what [FS #15] said. [FS #15] went to stop [client #5] was walking out. [Client #5] started to swing on [FS #15], [FS #15] then put him in a therapeutic wrap."</p> <p>Interview on 4/7/2020 Staff #3 stated: -Staff #3 had to recently put client #5 in a therapeutic hold twice on the same day. -The first incident occurred about 1 pm when client #5 went out the front door "like he was about to run." When Staff #3 followed to monitor client #5, the client struck the staff with the outdoor security sign, ran to the back yard and picked up a brick. -The second incident occurred around 2:30 pm when Staff #3 went to empty an ash tray. Client #5 tried to "fight him," so he had to put him another therapeutic hold.</p> <p>Interview on 4/13/2020 FS #15 stated: -When he worked he was the only staff on duty</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 17</p> <p>with 6 clients. Three of the clients were violent, 1 was a "run a way," and the other 2 were non-verbal. He had told his manager that they needed more staff on nights several times.</p> <p>-On 3/18/2020 client #5 was trying to go outside around 5:30 am - 6 am. He was wearing only a tank top and his night shorts, and no shoes. He told the client he could not go out, he needed to put on some pants.</p> <p>-Client #5 tried to run outside, and FS #15 stood in front of the door. Client #5 grabbed FS #15 with one hand and started hitting FS#15 with his other hand. When FS #15 tried to put client #5 into a therapeutic hold they both fell to the floor because of the client's body weight. Client #5 "weighed 300 pounds."</p> <p>-The Lead Staff arrived after the restrictive intervention.</p> <p>-FS #15 informed the Lead Staff of what happened, and the Lead Staff called the Group Home Manager.</p> <p>-FS #15 denied he ever put his hands on client #5 until after the client attacked him. When he stood between client #5 and the door, that was when the client started "screaming and scratching."</p> <p>-He had told his manager he felt they needed more than 1 staff on the night shift.</p> <p>Interview on 4/13/2020 the Lead staff stated he had called the Group Home Manager on 3/18/2020 before he left the facility and she talked with client #5 on the phone.</p> <p>Interview on 4/13/2020 the Group Home Manager stated:</p> <p>-The Lead Staff called her the morning of 3/18/2020 and told her client #5 had a behavior.</p> <p>-She did not recall speaking with the client on the phone.</p> <p>-She was not informed there had been a</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 18</p> <p>therapeutic hold or that the client was injured, therefore, had not reported to the QP. -FS #15 had never told her they needed more than 1 staff on the night shift.</p> <p>Interview on 4/7/2020 the QP stated: -Client #5 was an "emergency placement" on 11/22/2019. -They had seen an increase in client #5's verbal and physical aggressive behaviors recently. His physician had decreased some of his psychotropic medications because he was overweight and she thought this may have been a contributing factor. -His medications had been adjusted during his most recent hospitalization. -No one informed her that client #5 had a behavior on 3/18/2020 until she was called by client #5's guardian around 4:25pm that afternoon. -Without being notified, she had not been able to follow up with the client about his behaviors or the events that followed on the morning of 3/18/2020. -They were in the process of having a behavior plan developed.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.</p>	V 112		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities,</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 19</p> <p>or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 20</p> <p>exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to provide services to meet client needs within the scope of the facility's licensure affecting 1 of 1 clients audited (client #5). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record reviews and interviews, 1 of 1 Qualified Professional (QP) audited failed to demonstrate knowledge, skills and abilities required by the population served.</p> <p>Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110). Based on record reviews and interviews, 2 of 3 paraprofessional staff audited (Lead Staff, Group Home Manager) and 1 of 1 former staff audited (Former Staff (FS) #15) failed to demonstrate</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 21</p> <p>knowledge, skills, and abilities required by the population served.</p> <p>Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on interviews and record reviews, the facility failed to develop and implement treatment plan strategies to prevent and/or respond to aggressive behaviors for 1 of 1 clients audited. (client #5).</p> <p>Cross Reference: 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL (V318). Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation.</p> <p>Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366). Based on record reviews and interviews the facility failed to implement incident response policies as required to attend to the health and safety needs of individuals involved.</p> <p>Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record reviews and interviews, the facility failed to report all level II and level III incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents.</p> <p>Review on 4/15/2020 of a "Plan of Protection" signed and dated on 4/15/2020 by the Licensee</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 22</p> <p>revealed:</p> <p>- "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? In order to immediately correct the above rule violations in order to protect clients from further risk or additional harm, the Agency will review its policies and procedures as it relates to staff training, staff supervision, and internal incident reporting requirements, as well as incident reporting requirements for the LME/MCO, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the Division of Health Service Regulation (DHSR), and local Department of Social Services (DSS), when applicable."</p> <p>- "Describe your plans to make sure the above happens. The Agency's Quality Assurance and Quality Improvement (QA/QI) Committee will review policies and procedures as it relates to staff training, staff supervision, and internal incident reporting requirements in conjunction with the director. Upon this review, the Agency will immediately revise any policies based on the Committee's recommendation.</p> <p>The QPs will develop annual supervision plans to be monitored and reviewed quarterly by the director that reflect their roles and responsibilities. The QPs will continue to ensure that each home manager, lead staff, and paraprofessional have a current annual supervision plan, and will monitor these plans at least quarterly.</p> <p>The QPs will provide additional training with the home managers, lead staff, and paraprofessionals on the individuals' treatment plans, including but not limited to, the Individual Support Plan (ISP) and Positive Behavior Support Plan (PBSP) (the staff at House #2 will</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 23</p> <p>immediately receive this training). The Agency's Human Rights (HR) Committee will continue to review all incident reports and PBSPs quarterly, and as needed. The Agency's Internal Review Committee will continue to review and provide recommendations for all Level III incidents within 24 hours of notification of the incident.</p> <p>The director will conduct refresher training with the QPs on incident reporting requirements for the LME/MCO, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the Division of Health Service Regulation (DHSR), and local Department of Social Services (DSS). The QPs will then conduct this training with the home managers."</p> <p>Client #5 was a 42 year old male admitted 11/22/19 with diagnoses to include bipolar with severe psychotic features, intermittent explosive disorder, and mild intellectual and developmental disabilities. He had a history of fighting with staff, and not being able to smoke was a known crisis "trigger." Client #5 had no goals or strategies in his treatment plan to address smoking behaviors or physical aggression. Between 3/18/2020 and 3/22/2020 client #5 was placed in 3 restrictive interventions, sustaining injuries during the 3/18/2020 incident. The Lead Staff arrived at the facility before 7 am on 3/18/2020 and observed client #5 had been in a therapeutic hold and had blood on his lip. The Lead Staff informed the Group Home Manager and left the facility without assessing client #5's injuries. The incident was not reported to the QP. On 3/18/2020 around 4:25 pm client #5's guardian informed the QP that client #5 made an allegation of abuse against FS #15. Client #5 was taken to the emergency room that evening and diagnosed with, "Head</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 24 injury...Contusion of abdominal wall." The facility did not report the allegation of abuse to the HCPR within 24 hours, or submit a Level III IRIS report. The failures of internal and external reporting, failure to respond to Level II and III incidents, and the delay in seeking medical evaluation of client #5's injuries on 3/18/2020 constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$1,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 318	130 .0102 HCPR - 24 Hour Reporting 10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of learning about the allegation. The findings are:	V 318		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 318	<p>Continued From page 25</p> <p>Interview on 4/7/20 and 4/9/2020 the Qualified Professional(QP) stated: -She learned of an allegation of abuse on 3/18/2020. -Client #5's guardian called the QP on 3/18/2020 around 4:25 pm and told the QP that she had received a phone call from client #5. Client #5 told his guardian the staff had punched him in the stomach and hit his mouth on the morning of 3/18/2020. -The allegation was against Former Staff (FS) #15. -The QP had faxed the initial allegation and her internal investigation to the HCPR. The QP could not recall with whom she spoke at the HCPR, but would send the surveyor documentation of her report.</p> <p>Record review on 4/16/2020 of a FAX cover sheet dated 4/16/2020 from the QP revealed the name and phone number of the HCPR investigator to whom she had reported the allegation dated 3/18/2020.</p> <p>Interview on 4/16/2020 the HCPR Investigator stated: -The Initial Investigation and the Final Investigation reports had been received at the same time from the facility QP on 3/23/2020. -The reports documented the incident date was 3/18/2020 and the facility became aware of the allegation on 3/18/2020.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.</p>	V 318		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 26	V 366		
V 366	<p>27G .0603 Incident Response Requirments</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 27</p> <p>by:</p> <p>(1) immediately securing the client record</p> <p>by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 28</p> <p>available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement incident response policies as required to attend to the health and safety needs of individuals involved. The findings are:</p> <p>Review on 4/9/2020 and 4/13/2020 of client #5's record revealed: -42 year old male admitted 11/22/19. -Diagnoses included bipolar with severe psychotic features; intermittent explosive disorder; mild intellectual and developmental disabilities; borderline diabetic; hypertension; acid reflux; and, chronic obstructive pulmonary disease.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 29</p> <p>Review on 3/30/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility incidents on 3/18/2020 revealed:</p> <ul style="list-style-type: none"> -Client #5 had been placed in a therapeutic hold by Former Staff (FS) #15 at 6 am on 3/18/2020. -During the therapeutic hold client #5 hit his head on the floor when he and FS#15 fell. -While on the floor, client #1 came out of her room and began attacking client #5 by kicking him in his side and head. -There were no injuries documented in the IRIS report. <p>Review on 4/9/20 of client #5's Emergency Department record dated 3/18/2020 revealed:</p> <ul style="list-style-type: none"> -After Visit Summary printed at 8:30 pm on 3/18/2020. -Reason for visit, "Assault Victim." -Diagnoses, "Head injury...Contusion of abdominal wall." -Imaging tests performed: CT (computed tomography) without contrast of the head, and x-ray of the abdomen, 1 view KUB (kidneys, ureters, and urinary bladder). <p>Interview on 4/9/2020 client #5's Guardian stated:</p> <ul style="list-style-type: none"> -Client #5 called her at 4 pm on 3/18/2020 and told her he was in a lot of pain and hurting because the staff punched him in the face (FS #15), that he had a mouth full of blood, and his stomach hurt, in his words, "like a son of a gun." She asked if he had told the staff and he said, "no." -After talking with client #5 on the phone, she spoke to the Lead Staff and was told he (Lead Staff) had come into work that morning and client #5 was in a "full on rage," and had been "contained" when he got to him. She called the Qualified Professional (QP) and was told the QP 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 30</p> <p>knew nothing about the situation and would need to gather some information. She was told a 3rd staff came to work after the incident and saw client #5 with a mouth full of blood and crying. -She was concerned that 3 staff saw client #5 with blood coming from his mouth and not one reported the incident or got client #5 any help until client #5 called her at 4 pm.</p> <p>Interview on 4/13/2020 FS #15 stated: -On 3/18/2020 he and client #5 fell to the floor during a therapeutic hold. -When on the floor client #1 came out of her room and started hitting client #5 with a shirt, then kicked him twice in the head. At this point client #5's head hit the floor and he started bleeding from his mouth. -The Lead Staff arrived after the therapeutic hold and was informed by FS #15 of what happened. -The Lead Staff talked to client #1 and client #5, and called the Group Home Manager. -As instructed by the Lead Staff, he documented the incident, finished administering medications, completed required documentation and clocked out between 7 am and 7:30 am. -When asked if client #5 was assessed for injuries, FS #15 stated client #5 had a little blood on his lip. -Because he had reported the incident to the Lead Staff and the Lead Staff had notified the Group Home Manager, he did not notify his manager or the QP.</p> <p>Interviews on 4/7/2020 and 4/13/2020 the Lead Staff stated: -On the morning of 3/18/20, he went to the facility to deliver some keys to FS #15. -When he walked in FS#15 and client #5 were on the floor in the hall. Client #5 was spitting on FS#15 and name calling.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 31</p> <p>-Client #5 calmed down and was allowed to sit in the office with FS #15 as he, client #5, requested.</p> <p>-Client #5 had blood on his mouth. His lip was not swollen.</p> <p>-He did not look at the client #5's lip to see if he had a cut. He thought FS #15 assessed the client's injury.</p> <p>-Before the Lead Staff left he called the Group Home Manager and she talked with client #5 on the phone.</p> <p>Interview on 4/13/2020 Staff #10 stated:</p> <p>-When she arrived on 3/18/2020 to work day shift, the Lead Staff was exiting the home. He walked to her car and told her there had been an incident.</p> <p>-When she went inside client #5 was sitting in a chair near the door, crying, and was talking on the phone. His mouth was bloody.</p> <p>Interview on 4/7/2020 Staff #3 stated:</p> <p>-On 3/18/2020 when he reported to work the day shift, client #5 was sitting in a chair with a bloody lip. Staff #3 could not see where the blood was coming from. The blood was dried. Client #5's lip was not swollen.</p> <p>-The staff administered first aid by cleaning client #5's lip and applying Neosporin (antibiotic ointment). Client #5 did not complain of pain.</p> <p>Interview on 4/13/2020 the Group Home Manager stated:</p> <p>-The Lead Staff called her the morning of 3/18/2020 and told her client #5 had a behavior. She was not informed there had been a therapeutic hold or that the client was injured.</p> <p>-She did not recall speaking with client #5 on the phone.</p> <p>-When she learned in the afternoon on 3/18/2020 of client #5's therapeutic hold and injuries, she</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	<p>Continued From page 32</p> <p>returned to the home and interviewed staff and client #1. She had staff and client #1 to write statements.</p> <p>-After notification by the guardian, they tried to get client #5 to agree to go to the emergency room. At first he did not want to go. She talked with him and he finally agreed. He had told his guardian he had pain in his side.</p> <p>-Client #5 went to the emergency room around 6 pm -7 pm on 3/18/2020.</p> <p>Interview on 4/7/2020 the QP stated:</p> <p>-On 3/18/2020 she received a call from client #5's guardian around 4:25 pm. The guardian said client #5 had called her (the guardian) and reported he had been hit by the staff earlier that morning.</p> <p>-The incident had happened around 6 am with FS#15.</p> <p>-No one had informed the QP there had been an incident on 3/18/2020 with FS#15.</p> <p>-The first she heard of this was when the guardian called.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.</p>	V 366		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 33</p> <p>90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 34</p> <p>Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II and level III</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 35</p> <p>incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents. The findings are:</p> <p>Review on 3/30/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility in March 2020 revealed: -One level II incident for a restrictive intervention of client #5 by Former Staff (FS) #15 at 6 am on 3/18/2020. The report did not include client injuries or emergency department visit. -No IRIS reports for restrictive interventions on 3/22/2020. -No level III IRIS report for allegation of abuse on 3/18/2020.</p> <p>Review on 4/8/2020 of internal incident reports dated 3/22/2020 revealed: -At 2 pm on 3/22/2020 Staff #3 put client #5 in a standing restraint for 1 minute to prevent harm to the client and "others." Staff #3 documented client #5 had hit the staff with the metal part of a sign, then picked up a brick and attempted to throw the brick at the staff. -At 3:45 pm on 3/22/2020 Staff #3 realized client #5 was smoking cigarette butts from an ashtray. When Staff #3 started to empty the ashtray, client #5 "began attempting to fight staff and threatening to harm himself." Staff placed [client #5] in therapeutic hold.</p> <p>Interview on 4/7/2020 Staff #3 stated: -Staff #3 had to put client #5 in a restrictive intervention twice on 3/22/2020. -The first incident occurred about 1 pm when client #5 went out the front door "like he was about to run." When Staff #3 followed to monitor client #5, the client struck the staff with the outdoor security sign, ran to the back yard and</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	<p>Continued From page 36</p> <p>picked up a brick.</p> <p>-The second incident occurred around 2:30 pm when Staff #3 went to empty an ash tray. Client #5 tried to "fight him," so he had to put him another therapeutic hold.</p> <p>-Staff #3 notified his manager and Qualified Professional (QP). He also documented 2 separate incident reports for the 2 restrictive interventions.</p> <p>Interview on 4/7/2020 and 4/9/2020 the QP stated:</p> <p>-She learned of an allegation of abuse on 3/18/2020 from client #5's guardian. The allegation was against FS #15. An IRIS report had been submitted.</p> <p>-The QP had reported this allegation to the Health Care Personnel Registry (HCPR) and the department of Social Services. She would provide documentation of the HCPR reporting.</p> <p>-There was an internal incident report for a restrictive intervention of client #5 on 3/22/2020.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 and must be corrected within 23 days.</p>	V 367		
V 517	<p>27E .0104(c-d) Client Rights - Sec. Rest. & ITO</p> <p>10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL</p> <p>(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 37</p> <p>(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews 1 of 1 Former Staff (FS #15) audited failed to use a restrictive intervention in a manner that would not cause harm or abuse for 1 of 1 clients audited (client #5). The findings are:</p> <p>Review on 4/9/2020 and 4/13/2020 of client #5's record revealed: -42 year old male admitted 11/22/19. -Diagnoses included bipolar with severe psychotic features; intermittent explosive disorder; mild intellectual and developmental disabilities; borderline diabetic; hypertension; acid reflux; and, chronic obstructive pulmonary disease.</p> <p>Review on 4/8/2020 of FS #15's personnel file revealed: -Date of Hire: 2/26/18. -Involuntary Termination date: 3/30/2020 -Position: Paraprofessional -Reason for termination: Allegation of abuse -EBPI (Evidence Based Protective Interventions) - Base completed 3/5/19, expiration 3/31/2020.</p> <p>Review on 3/30/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility incidents on 3/18/2020 revealed: -Client #5 had been placed in a therapeutic hold by Former Staff (FS) #15 at 6 am on 3/18/2020. -During the therapeutic hold client #5 hit his head on the floor when he and FS#15 fell.</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 38</p> <p>-While on the floor, client #1 came out of her room and began attacking client #5 by kicking him in his side and head.</p> <p>-There were no injuries or medical evaluation documented in the IRIS report.</p> <p>Review on 4/9/20 of client #5's Emergency Department record dated 3/18/2020 revealed: -Reason for visit, "Assault Victim." -Diagnoses, "Head injury...Contusion of abdominal wall." -Imaging tests performed: CT (computed tomography) without contrast of the head, and x-ray of the abdomen, 1 view KUB (kidneys, ureters, and urinary bladder).</p> <p>Review on 4/16/2020 of the Department of Social Services Adult Protective Services Social Worker (DSS-APS-SW) summary dated 3/20/2020 revealed: -The DSS-APS-SW interviewed client #5 on 3/20/2020. -"... Adult (client #5) stated that 2 days ago he was trying to go outside and get fresh air and while he was going the staff member grabbed him from behind. He stated that he told him 3 times to stop grabbing him from behind, but he continued, and adult stated at that point he swung. He stated that the staff member then slammed him down on the ground and then began punching him in the face and stomach and resident (client #1) kicked him. He stated that he does not know that staff members name. SW observed adult's lip which appears to be healing from a busted lip. Adult stated that he told his guardian what happen but could not tell SW who his guardian was."</p> <p>Review on 4/15/2020 of client #1's statement revealed:</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 39</p> <p>-"[Client #5] wanted to go outside. Staff [FS #15] said yes you could go outside once you put a jacket on because it's cold outside. [Client #5] then started walking down the hallway. While [client #5] was walking down the hallway he was using very bad language. [FS #15] told [client #5] to stop using that kind of language if not you will not go outside. [Client #5] wouldn't stop so [FS #15] said now you have to wait until i'm done giving meds. (medications) so I could go outside with you. [Client #5] continue to go out the front door not caring what [FS #15] said. [FS #15] went to stop [client #5] was walking out. [Client #5] started to swing on [FS #15], [FS #15] then put him in a therapeutic wrap. as doing so [client #5] was on the floor. [FS #15] told [client #5] if I let you up and you start this again i have to put you back in the wrap. [FS #15] started to hit [client #5] in the stomach and [FS #15] had put him in another wrap after he tried to get up. [Client #5] was calling [FS #15] a "n***a." [Client #1] Jumps in and Started to hit him. She bust his lip and hit him in his side toward his back. [Lead Staff] walked in and Dropped off the keys. [FS #15] Still had [client #5] in the wrap. [Lead Staff] asked [FS #15] was everything o.k. [FS #15] said I got it so [Lead Staff] left. Moments later [FS #15] asked [client #5] was you calm. [Client #5] said yes. [FS #15] let him get up, [client #5] walked outside and [FS #15] started popping his meds. [Client #5] walked in the house and apologized to [FS #15] as he was crying. [FS #15] said to [client #5] it's ok we all have bad days."</p> <p>Review on 4/8/2020 of FS #15's written statement (undated) revealed: -"On March 18th around 6 am staff was handing out meds when individual was trying to go outside with a tank top and shorts, staff then redirected individual to go put on proper clothes so he can</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 40</p> <p>go outside. Individual then called staff racist names and said staff's mother is a "B." Individual then ran to front door and staff got in front of him. Individual began swinging and staff put individual in therapeutic hold then individual fell down on ground and while on ground another individual began attacking [client #5], so staff redirected other individual and began calming [client #5] down. Individual (client #5) then began to cry and apologizing to staff. Staff let individual (client #5) stay in med room to calm down when other staff arrived to facility. Lead Staff was present when staff was getting individual off the ground."</p> <p>Interview on 4/9/2020 client #5's Guardian stated: -Client #5 called her at 4 pm on 3/18/2020 and told her he was in a lot of pain and hurting. When she asked him why he was in pain he told her the staff punched him in the face (FS #15), that he had a mouth full of blood, and his stomach hurt, in his words, "like a son of a gun." She asked if he had told the staff and he said, "no." She spoke to the Lead Staff on the phone and was told he (Lead Staff) had come into work that morning and client #5 was in a "full on rage," and had been "contained" when he got to him. She called the Qualified Professional (QP) and was told she (QP) knew nothing about the situation and would need to gather some information. She talked to the QP the following day, 3/19/20, and was told client #5 had been taken to the emergency department that night (3/18/20) to be evaluated. On the following Friday she received a progress note about what had happened. She was told another client (client #1) said she saw the staff hit client #5 and that this client (client #1) also hit client #5. Also, a 3rd staff came to work after the incident and saw client #5 with a mouth full of blood and crying.</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 41</p> <p>Client #5 was not interviewed due to his Guardian's expressed concerns it may upset him and he would resume saying he wanted to find a different place to live, which he had been saying prior to this incident.</p> <p>Interview on 4/13/2020 client #1 stated: -She remembered the day client #5 and FS #15 got into an altercation. -Client #1's voice raised and she stated "[FS #15] did not hit nobody, he is righteous..."FS #15 was a "wonderful employee" and "he did nothing wrong." -She stated no one had asked her if FS #15 hit client #1. -She was asked to write a statement and she had done this, but did not have a copy. -She never told anyone that FS #15 hit client #5.</p> <p>Interview on 4/13/2020 FS #15 stated: -He had worked at the facility for 2 years and had been terminated 1-2 weeks prior. -He was the only staff on the night shift with 6 clients on 3/18/2020. Three of the clients were violent, 1 was a "run a way," and the other 2 were non-verbal. -On his last day, (3/18/2020) client #5 was trying to go outside around 5:30 am - 6 am. Client #5 was wearing only a tank top and his night shorts, and no shoes. FS #15 told client #5 he could not go out with the Corona virus and needed to put on some pants. -Client #5 became irate and started calling him the "N" word. FS #15 was giving the morning medications. Client #5 tried to run outside, and FS #15 stood in front of the door. Client #5 grabbed FS #15 with one hand and started hitting the staff with his other hand. FS #15 tried to put client #5 into a therapeutic hold. Client #5 was biting FS #15's fingers. They both fell to the floor.</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 42</p> <p>Client #5 "weighed about 300 pounds." This happened inside the home in the hallway.</p> <ul style="list-style-type: none"> -When client #5 became irate FS #15 told the other clients to go to their room. -When FS #15 and client #5 fell, client #1 came out of her room and started hitting client #5 with a shirt, then kicked him twice in the head. At this point client #5's head hit the floor and FS #15, using his forearm, pushed himself up off the client using his body weight. When he got up he put client #1 back in her room. Client #5 was "tired out," he was "breathing hard," and he started making verbal threats that he would get FS #15 fired. -About 5 minutes later the first day shift staff and Lead Staff arrived. Client #5 was sitting in the office talking with FS #15 when the first day shift staff arrived. -FS #15 finished giving the medications and completed an incident report before he clocked out as instructed by the Lead Staff. -When asked if client #5 was assessed for injuries, FS #15 stated the client had "a little blood on his lip." Client #5 did not start bleeding until client #1 kicked him. -FS #15 denied he ever put his hands on client #5 until after the client attacked him. When FS #15 stood between client #5 and the door, client #5 started "screaming and scratching." -FS #15 "clocked out" between 7 am and 7:30 am. He was called later that day and told he was being taken off the schedule. One week later he was called by the QP and terminated. -He had worked for the facility 2 years, and never had anything like this happen before. -Prior to this he had not used any restrictive interventions. <p>Interview on 4/13/2020 the Lead Staff stated:</p> <ul style="list-style-type: none"> -When the Lead Staff walked into the facility on 	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 43</p> <p>3/18/2020, FS #15 was trying to get up from the floor. Client #5 was on the floor, spitting, trying to bite FS #15, and making derogatory remarks.</p> <p>-The Lead Staff talked with client #1 on the morning of 3/18/2020 and client #1 never mentioned she (client #1) saw FS #15 hit client #5. Client #1 said that she (client #1) hit client #5. Knowing client #1, the Lead Staff stated he believed if client #1 had seen FS #15 hit client #5, she (client #1), would have told him that morning.</p> <p>-The Lead Staff did not see FS #15 hit client #5.</p> <p>-The Lead Staff had never had any problems with FS #15. FS #15 had been able to deal with clients and not become reactionary in past, similar situations.</p> <p>-He did not believe FS #15 would have hit client #5, he was a good employee.</p> <p>Interview on 4/13/2020 the Group Home Manager stated:</p> <p>-When she learned of the therapeutic hold on 3/18/2020 and client #5's injuries, she went to the facility and interviewed staff and client #1. She had them to write statements.</p> <p>-Client #1 never told the Group Home Manager she saw FS #15 hit client #5. She asked client #1 what happened, and client #1 said, "I plead the 5th."</p> <p>-Client #1 wrote a statement. She read the statement but could not recall what client #1 wrote. She did not recall client #1 writing in her statement that she saw FS #15 hit client #5.</p> <p>-She was sure that client #1 never told a staff that she saw FS #15 hit client #5 because her staff would have told her.</p> <p>Interview on 4/7/2020 the QP stated:</p> <p>-She (QP) received a call from client #5's guardian around 4:25 pm on 3/18/2020. The guardian reported she had received a call from</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 44</p> <p>client #5 and he told her he had been punched in the stomach and hit in his mouth by a staff.</p> <p>-The incident happened around 6 am on 3/18/2020. The staff was FS #15. He was working 3rd shift, 11 pm - 7 am. There was only 1 staff on the night shift; therefore, no other staff were on duty to witness the incident.</p> <p>-Client #1 also kicked client #5 trying to assist FS #15.</p> <p>-The Licensee interviewed client #1 over the phone and client #1 admitted that she (client #1) saw the FS #15 hit client #5 twice.</p> <p>Interview on 4/7/2020 the Licensee stated:</p> <p>-When asked if he had knowledge of any recent allegations of abuse, neglect, or exploitation he stated he was not aware of any allegation at "Serenity #2."</p> <p>-When asked if he recalled any recent restrictive interventions and he said there had been some restrictive interventions with client #1 due to her behaviors.</p> <p>-There had been no reports of incorrect restrictive interventions.</p> <p>Review on 4/15/2020 of a "Plan of Protection" signed and dated on 4/15/2020 by the Licensee revealed:</p> <p>-"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? In order to immediately correct the above rule violations in order to protect clients from further risk or additional harm, the Agency will review its policies and procedures as it relates to Evidenced Based Protective Interventions (EBPI) and the use of restrictive interventions."</p> <p>-"Describe your plans to make sure the above happens. The Agency's Quality Assurance and Quality Improvement (QA/QI) Committee will</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	<p>Continued From page 45</p> <p>review policies and ;procedures as it relates to Evidenced Based Protective Interventions (EBPI) and the use of restrictive interventions in conjunction with the director. Upon this review, the Agency will immediately revise any policies based on the Committee's recommendation.</p> <p>The Agency's EBPI trainer will provide additional training to the home managers, lead staff, and paraprofessionals on EBPI and the use of restrictive interventions. the QPs will provide additional training on how and when restrictive interventions should be used based on the individuals' treatment plans, including but not limited to, the Individual Support Plan (ISP) and Positive Behavior Support Plan (PBSP). The QPs will also provide additional training on abuse, neglect, and exploitation. The Agency's Human Rights (HR) Committee will continue to review all incident reports and PBSPs quarterly, and as needed. The Agency's Internal Review Committee will continue to review and provide recommendations for all Level III incidents within 24 hours of notification of the incident, including but not limited to, allegations of abuse.</p> <p>The staff at House #2 will immediately receive additional training on EBPI and on how and when restrictive interventions should be used based on the individuals' treatment plans, including but not limited to, the Individual Support Plan (ISP) and Positive Behavior Support Plan (PBSP)."</p> <p>Client #5 was a 42 year old male admitted 11/22/19 with diagnoses to include bipolar with severe psychotic features, intermittent explosive disorder, and mild intellectual and developmental disabilities. Around 6 am on 3/18/2020 Client #5's behaviors escalated from verbal name calling to physically trying to hit FS #15 when the staff</p>	V 517		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-890	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2	STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 517	Continued From page 46 prevented him from going outside. FS #15 placed client #5 in a therapeutic hold and they both fell to the floor. During this incident, client #5 hit his head on the floor, cut his lip, and sustained blows to his head and side by a peer (client #1). That evening Client #5 was diagnosed in the Emergency room with "Head injury...Contusion of abdominal wall." The failure of FS #15 to use proper de-escalation and restrictive intervention techniques resulted in client #5's injuries. This constitutes a Type A1 deficiency for serious harm and must be corrected within 23 days. An administrative penalty of \$1,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 517		