STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411142	A. BUILDING: ______ B. WING ______	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HOUSE	**1700 FAIRVIEW STREET #153 GREENSBORO, NC 27405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on 2/17/22. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. The survey sample consisted of audits of 2 current clients.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	V 367		

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V 367	Continued From page 1 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A 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;	V 367		

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V 367	Continued From page 2	V 367		

(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure Level II incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are:

Review on 2/11/22 of client #2's record revealed:
- An admission date of 1/12/22
- Diagnoses of Autism Spectrum Disorder (D/O); Attention Deficit Hyperactivity D/O; Sotos Syndrome and Unspecified Intellectual Disabilities

Review on 2/11/22 of the facility's in-house incident reports revealed:
- A "General Event Report" completed by staff (#2) on 2/4/22 which revealed on 2/3/22 at 7:30 pm, client #2 became upset when staff put an iPad away after she used it to document having

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V 367	Continued From page 3 administered client #1's medications to him - "...Putting the ipad away upset [client #2] and he started to hit himself by taking his fist and punching himself in the legs and the side of his head so staff asked [client #2] to go to his room were he continued to scream yell punch and kick the walls..." - "...Staff tried entering the room to check on [client #2] and he started to throw things at staff. I went to check on Staff (#3) and [client #2] and upon entering the room I observed [client #2] hit his head onto the headboard and continued to kick the wall until he kicked a hole in it. Staff tried to redirect [client #2] by offering a snack and shower but [client #2] would not calm down. [Client #2] also punched a hole into his bedroom wall and kept slamming doors and screaming..." - Staff #2 called the House Manager to notify her of the situation and remained at the facility with staff #3 until the House Manager's arrived at the facility - "...Due to noise and banging the neighbors called the police..." - Once the House Manager arrived at the facility, client #2 calmed down and the House Manager was able to talk with him Review on 2/11/22 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No Level II incident report had been submitted to IRIS regarding client #2's behavior and police being called Interview on 2/14/22 with the House Manager revealed: - A neighbor called the police on the evening of 2/3/22 due to all of the noise client #2 was making - When the police arrived at the facility, she informed the officers that client #2 resided in a	V 367		

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V 367	Continued From page 4 group home and he was having a behavior - The officers told the House Manager they understood and to call them should she need any assistance - There was no further involvement by the police that evening as client #2 eventually calmed down - She had not submitted this information to IRIS as she had believed to be a level I incident only. Interview on 2/11/21 with the Director revealed: - This information had not been submitted to the IRIS as she believed it to be a level I incident only.	V 367		