STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
			P WING		R
		MHL036-337	B. WING		02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
OFDENIT	(1101105	508 N RA	NSOM STREET		
SERENITY	HOUSE	GASTON	IA, NC 28054		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000		
	completed on 2/17/22 unsubstantiated (Intal complaint was substa #NC00184113). Defice This facility is licensed	ke #NC00184274) and one ntiated (Intake ciencies were cited.  d for the following service 27G .1700 Residential			
	The survey sample co	onsisted of audits of 3 former clients.			
V 107	27G .0202 (A-E) Pers	connel Requirements	V 107		
	which:  (1) specifies the competency, work exqualifications for the p (2) specifies the the position; (3) is signed by supervisor; and (4) is retained in (b) All facilities shall each staff member or provides care or servithe facility: (1) is at least 18 (2) is able to reafollow directions;	have a written job ector and each staff position eminimum level of education, perience and other position; eduties and responsibilities of the staff member and the in the staff member's file. ensure that the director, any other person who ices to clients on behalf of			
		perience, skills and other			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE	
SERENIT	V HOUSE	508 N RA	NSOM STREET		
SERENII	T HOUSE	GASTONI	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 107	neglect listed on the I Personnel Registry.  (c) All facilities or ser applicants for employ conviction. The impa decision regarding en upon the offense in re which the applicant is (d) Staff of a facility of currently licensed, re- accordance with appl services provided.  (e) A file shall be ma employed indicating to	tantiated findings of abuse or North Carolina Health Care  vices shall require that all ment disclose any criminal ct of this information on a apployment shall be based elationship to the job for applying.  or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including	V 107		
	failed to ensure a writ present in each staff of 10 audited staff (Staff Manager) and failed to met the minimum edu their position affecting #4 and #6). The findi	nd record review, the facility ten job description was member's file affecting 5 of #1, #2, #4, #5, and House to ensure each staff member ucation requirements for g 2 of 10 audited staff (Staff			
	-Hired 7/31/21; -Employed as Reside	ential Assistant;			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MIII 000 007	B. WING		R
		MHL036-337			02/17/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ΓE, ZIP CODE	
SERENITY	HOUSE		NSOM STREET IIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 107	Continued From page	2	V 107		
	-No job description av	vailable for review.			
	Review on 2/14/22 of -Hired 9/29/21; -Employed as Reside -No job description av				
	Review on 2/14/22 of -Hired 1/29/22; -Employed as Reside	Staff #4's record revealed:			
	Review on 2/14/22 of -Hired 9/9/21; -Employed as Reside -No job description av				
	-Hired 10/9/21; -Employed as Reside	Staff #6's record revealed: ntial Assistant; tials available for review.			
	Review on 2/14/22 of record revealed: -Hired 3/30/20; -No job description av	the House Manager's vailable for review.			
	Professional #2 revea	e personnel files were escriptions and education by descriptions and			
	NCAC 27G .1701 Sco	ss referenced into 10A ope (V293) for a Type A1 st be corrected within 23			

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STATE FORM 6899 D4PS11 If continuation sheet 3 of 79

DIVISION	n Health Service Negu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-			
		MHL036-337	B. WING		02/17/2	2022
NAME OF PI	ROVIDER OR SUPPLIER	STREETADL	RESS, CITY, STA	ILE, ZIP CODE		
SERENITY	LIOUEE	508 N RAN	SOM STREET			
SEKENIII	HOUSE	GASTONIA	, NC 28054			
0/10/15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 107	Continued From page	÷ 3	V 107			
	d					
	days.					
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	, ,	•				
	10A NCAC 27G .0202	PERSONNEI				
	REQUIREMENTS	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				
		ion shall be documented.				
	( )					
	(g) Employee training					
	=	nimum, shall consist of the				
	following:					
	(1) general organiza					
	` ,	rights and confidentiality as				
	delineated in 10A NC	AC 27C, 27D, 27E, 27F and				
	10A NCAC 26B;					
	(3) training to meet t	he mh/dd/sa needs of the				
		he treatment/habilitation				
	plan; and					
	(4) training in infection	ous diseases and				
	• •					
	bloodborne pathogen					
		ed under 10a NCAC 27G				
		napter, at least one staff				
		lable in the facility at all				
	times when a client is	present. That staff				
	member shall be train	ed in basic first aid				
	including seizure mar	nagement, currently trained				
	to provide cardiopulm	onary resuscitation and				
		h maneuver or other first aid				
		nose provided by Red Cross,				
	the American Heart A	· •				
		ing airway obstruction.				
	(i) The governing boo					
		d procedures for identifying,				
		g and controlling infectious				
	and communicable di	seases of personnel and				
	clients.					

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHI 036.337		B WING		R		
		MHL036-337			02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA ANSOM STREET	•		
SERENITY	/ HOUSE		IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 108	Continued From page	· 4	V 108			
	failed to provide trainic clients affecting 10 of #2, #3, #4, #5, #6, Ho Professional #1, Licer #2, Licensed Professional #1, Licer and clinical needs.  Review on 2/14/22 of -Hired 7/31/21; -Employed as Reside -No training in sexual	nd record review, the facility ing to meet the needs of the 10 audited staff (Staff #1, buse Manager, Qualified insee-Qualified Professional ional). The findings are:  Ints' sexualized behaviors  Staff #1's record revealed:  Intial Assistant; Ity aggressive youth.  Staff #2's record revealed:  Intial Assistant;				
	Review on 2/14/22 of -Hired 5/15/21; -Employed as Reside -No training in sexual					
	Review on 2/14/22 of -Hired 1/29/22; -Employed as Reside -No training in sexual					
	Review on 2/14/22 of -Hired 9/9/21; -Employed as Reside -No training in sexual					
	   Review on 2/14/22 of	Staff #6's record revealed:				

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-Hired 10/9/21;

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL036-337		B. WING		R <b>02/1</b> 7	7/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	' HOUSE		NSOM STREET			
			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	Continued From page	e 5	V 108			
	-Employed as Reside -No training in sexual	ly aggressive youth.				
	record revealed: -Hired 3/30/20; -No training in sexual	the House Manager's ly aggressive youth.				
	Review on 2/14/22 of Qualified Professional #1's record revealed: -Hired 2/5/19; -No training in sexually aggressive youth.					
	Review on 2/14/22 of Professional #2's (L-C -Hired 2/5/19; -No training in sexual	QP#2) record revealed:				
	Review on 2/14/22 of record revealed: -Hired 10/1/20; -No training in sexual	Licensed Professional ly aggressive youth.				
	Interview on 2/15/22 with the L-QP#2 revealed: -Had not provided any staff training regarding sexually aggressive youth despite the incidents of sexualized behaviors at the facility; -Will secure staff training regarding sexually aggressive youth.					
		tutes a re-cited deficiency. een cited two times on				
	NCAC 27G .1701 Sco	ss referenced into 10A ope (V293) for a Type A1 st be corrected within 23				

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STATE FORM 6899 D4PS11 If continuation sheet 6 of 79

DIVISION	of Health Service Regu	lalion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
					R
		MHL036-337	B. WING		02/17/2022
	20,4252 02 0422452	OTDEET A	DDE00 01TV 0T4	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	I E, ZIP CODE	
SERENITY	/ HOUSE	508 N RA	NSOM STREET		
SERENIII	HOUSE	GASTON	IA, NC 28054		
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(710)
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF	
				DEFICIENCY)	
V 109	Continued From page	e 6	V 109		
V 400	070 0000 Daireita aire a	/Taninia a Danfornia a da	1,400		
V 109	27G .0203 Privileging	/Training Professionals	V 109		
		3 COMPETENCIES OF			
	QUALIFIED PROFES	SSIONALS AND			
	ASSOCIATE PROFE	SSIONALS			
	(a) There shall be no	privileging requirements for			
		s or associate professionals.			
	(b) Qualified professi	•			
		monstrate knowledge, skills			
	-	by the population served.			
	(c) At such time as a				
		s established by rulemaking,			
	then qualified profess				
	professionals shall de	monstrate competence.			
	(d) Competence shall	I be demonstrated by			
	exhibiting core skills in	ncludina:			
	(1) technical knowled	•			
	(2) cultural awarenes	<b>G</b> .			
	(3) analytical skills;	50,			
	(4) decision-making;				
	(5) interpersonal skil	•			
	(6) communication s	KIIIS; and			
	<ol><li>(7) clinical skills.</li></ol>				
	` '	onals as specified in 10A			
	NCAC 27G .0104 (18	)(a) are deemed to have			
	met the requirements	of the competency-based			
	employment system i	n the State Plan for			
	MH/DD/SAS.				
		dy for each facility shall			
	``	nt policies and procedures			
		individualized supervision			
		associate professional.			
		•			
	(g) The associate pro				
		fied professional with the			
	population served for	•			
	specified in Rule .010	4 of this Subchapter.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL036-337	B. WING		02	R 2/ <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	·	
SERENIT	YHOUSE		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 109	Continued From page	: 7	V 109			
	qualified professional: Licensee-Qualified Pr Professional) failed to knowledge, skills, and population served. The Review on 2/14/22 of (QP#1) record revealed. Hired 2/5/19; -Signed job description "provide and/or ass training for residential and training and staff develop task analys implementation of goat training and staff develop task analys implementation of goat training and staff develop task analys implementation of goat training and staff develop task analys implementation of goat training and staff develop task analys implementation of goat training and staff develop task analys implementation of goat training responsibilities a mini and 75% shall occur and adolescents are awaked management of the defacility, supervision or regarding responsibility implementation of each treatment plan"  Review on 2/14/22 of Professional #2's (L-CI-Hired 2/5/19; -Signed job description "provide and/or ass training for residential review and monitor seand employee attendation and employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential review and monitor seand employee attendation and the professional for residential for residential review and for residential for residential for residential fo	and record review, 3 of 3 is (Qualified Professional #1, ofessional #2, and Licensed of demonstrate the disabilities required by the ine findings are:  Qualified Professional #1's ed:  In dated 8/14/19 revealed:  In dated 1/27/19 revealed:				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. 23ILDING		R		
		MHL036-337	B. WING		02/17/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
SERENITY	'HOUSE		NSOM STREET			
	CLIMMADY CT		IIA, NC 28054	DDOWDEDIS DI ANI OF CODDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 109	Continued From page	e 8	V 109			
	•	in IRIS (North Carolina provement System)"				
	(LP) record revealed: -Hired 9/30/20; -Signed job description "face to face clinical provided in each facilmust provide clinical Qualified Professional treatment team on the the clientsinvolvem adolescents specific the programming"  Refer to V107 for failure requirements: -Staff records missing required education crief.	on dated 7/8/21 revealed: I consultation shall be ity at least 4 hours a week il supervision to the I monthlyupdate e progress of therapy with tent in the children or treatment plans and overall ure to meet personnel				
	-No training in sexual	ly aggressive youth despite d Former Client #4's (FC#4)				
	assessments:	re to complete admission				
	Clients #1, #2, #3, an behaviors;	strategies: ies developed to address d FC#4's sexualized ies developed to address				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BOILDING	A. Bolebino.	
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
SERENIT	/ HOUSE		ANSOM STREET IIA, NC 28054		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 109	Continued From page	9	V 109		
		ure to complete Health Care HCPR) checks prior to an npleted on Staff #4.			
	background checks w employment: -No criminal backgrou	ure to request criminal within 5 days of an offer of und check requested on			
	Staff #2, #4, and #6.  Refer to V294 for failure to provide required qualified professional services: -QP#1 did not provide services at the facility a minimum of 10 hours weekly with at least 70% of the time when clients were awake and present; -QP#1 did not schedule assessments or services to address Clients #1, #2, #3 and FC#4's sexualized behaviors; -QP#1 did not develop treatment strategies to address Clients #1, #2, #3, and FC#4's sexualized behaviors or FC#4's AWOL.				
	staffing ratios: -Only one staff preser times.	nt with up to four clients at			
	licensed professional -LP did not provide fa the clients weekly; -LP provided phone c clients for no more the -LP contact with clien -LP did not provide cli QP#1.  Refer to V336 for failu	ce to face consultation to alls or virtual visits to the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		:TED
		MHL036-337	B. WING		02/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
OFDENIT	, HOUSE	508 N RA	NSOM STREET			
SERENIT	HOUSE	GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 109	Continued From page	= 10	V 109			
		r tracking of Clients #1, #2, alized behaviors;				
	a safe, clean, attractivus -Debris on the front a -Cable lock on the babeing obstructed; -Holes and damages -Personal belongings client bedrooms;	ure to maintain the facility in ve, and orderly manner: nd side lawn; ack door resulting in the exit in Client #3's bedroom; a scattered on the floors in ors were chipped, scuffed,				
	-Client #1 reported se ago; -Client #1 wrote letter Former Client #4. Th submitted to the L-QF the letters; -Client #1 wrote letter Client #3. The letters two weeks ago; -FC#4 alleged Client and touched her in a -No assessment or se Client #1 regarding he because her authorizends 2/24/22; -No assessment or se Client #2 regarding he because she is scheen to assessment or se FC#4 regarding her se -Completed virtual visite agos.	ervices were secured for er sexualized behaviors ation to remain at the facility ervices were secured for er sexualized behaviors duled to discharge soon; ervices were secured for exexualized behaviors; sits to the facility;				
	-Completed most of h	ner work from the office; ents were in school and only				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED	
			71. 201221110		_	
			B. WING		R	
		MHL036-337	B. WING		02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
	/ II O II O E	508 N RA	NSOM STREET			
SERENIT	HOUSE	GASTON	IA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 109	Continued From page	<u> </u>	V 109			
V 100			1 100			
	saw the clients virtual					
	-Did not meet with the	e LP for clinical supervision.				
	Attampted interviews	with the LD were				
	Attempted interviews	est was made by Division of				
	·	ation (DHSR) on 2/14/22 at				
		#2 to arrange a telephone				
		ISR and the LP. Despite				
		telephone interview, no				
	telephone call was re	ceived from the LP. An				
	additional attempt wa	•				
		telephone call to the LP.				
	The following messag					
		less customer you are				
	-	e. Please try your call again				
	later."					
	Interviews on 2/9/22,	2/10/22, and 2/15/22 with				
	the L-QP#2 revealed:					
	-Was not aware some					
	credentials;	scriptions and education				
		y staff training regarding				
	sexually aggressive y sexualized behaviors	outh despite the incidents of at the facility;				
	-Was not sure if an ac	lmission assessment was				
	completed when Clier					
	-Moved client rooms					
	· · · · · · · · · · · · · · · · · · ·	nformation regarding letters				
	of sexual nature writte	-				
	-The first set of letters					
	_	en between Clients #1 and				
	#3 and were discover 2/5/22-2/6/22;	ed during the weekend of				
	-The second set of le	tters (totaling 6 pages				
		en between Client #1 and				
	FC#4;	z z mosn. onome // r una				
	-Not sure why there w completed on Staff #4					
		criminal background check				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL036-337	B. WING		R <b>02/17</b>	//2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE		NSOM STREET A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	Continued From page		V 109			
	were requested late for not identify the reason -Was aware the QP#* the facility for 10 hour time being when the cawake; -Was not aware the Cacility when the client -Tried to schedule two sometimes had difficustaff calling out resultition -Was not aware the Lacility to conduct their -Was not acceptable to the facility; -Did not complete incisexualized behaviors necessary; -It was an oversight the was not completed reallegation of unwante FC#4 against Client # investigation was com -Was not aware the dunobstructed; -Would remove the calif required.  This deficiency has be 7/29/19 and 10/3/19.  This deficiency is cross NCAC 27G .1701 Scc.	iminal background checks or Staff #4 and #6 but could h; I needed to be present in sweekly with 70% of the clients were present and P#1 was not present in the ts were present; o staff to work each shift but alty with staffing ratios due to ng in only one staff at times; P was not present at the rapy with the clients; the LP was not present at dent reports on the as she did not think it was nat a Level II incident report garding the 11/21/21 d sexual behavior made by 2, but an internal				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R
	MHL036-337	B. WING		02/17/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY HOUSE		NSOM STREET A, NC 28054		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 111 Continued From page	ge 13	V 111		
V 111 27G .0205 (A-B) Assessment/Treatm	ent/Habilitation Plan	V 111		
PLAN	LITATION OR SERVICE			
client, according to	shall be completed for a governing body policy, prior to ces, and shall include, but not			
be limited to: (1) the client's pres (2) the client's nee	enting problem;			
(3) a provisional or established diagnos of admission, excep detoxification or oth	admitting diagnosis with an is determined within 30 days t that a client admitted to a er 24-hour medical program			
admission; (4) a pertinent soci	ished diagnosis upon al, family, and medical history;			
(5) evaluations or a psychiatric, substan vocational, as appro (b) When services a establishment and in treatment/habilitation referred to as the "p	and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE		NSOM STREET		
	 I	GASTONI	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
V 111	Continued From page	e 14	V 111		
	failed to have strateging of services for 1 of 3. The findings are:  Review on 2/8/22 of 0.	as evidenced by: nd record review, the facility ies in place prior to delivery audited clients (Client #2).  Client #2's record revealed:			
	_	r-Traumatic Stress Disorder, corder, Attention Deficit er;			
	Assessments reveale	egies in place prior to the			
	the Licensee-Qualifie to Division of Health S dated 2/9/22 at 1:37p -"I was not able to (admission assessme [Qualified Professional				
	revealed: -Unable to locate the Client #2; -Acknowledged the a for review upon reque -Was not sure if an ac completed when Clien	dmission assessment was nt #2 was admitted; omplete an admission t #2;			

Division of Health Service Regulation

STATE FORM 6899 D4PS11 If continuation sheet 15 of 79

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
					F	t
		MHL036-337	B. WING		02/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE		ISOM STREET			
			A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 111	Continued From page	e 15	V 111			
	completed for Client # admitted to the facility	#2 and all future clients /.				
	NCAC 27G .1701 Sco	ss referenced into 10A ope (V293) for a Type A1 st be corrected within 23				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN  (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall incompose the projected date of achieved by provision projected date of achieved (2) strategies;  (3) staff responsible;  (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a session of the plan shall be provided in the plan shall be provi	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude: I that are anticipated to be a of the service and a devement; I view of the plan at least on with the client or legally roboth; I too or assessment of				

Division of Health Service Regulation

STATE FORM 6899 D4PS11 If continuation sheet 16 of 79

DIVISION	or riealin Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			1	<del>_</del>	_	,
			B WING		F	
		MHL036-337	B. WING		02/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		508 N R/	ANSOM STREET			
SERENITY	/ HOUSE		IIA, NC 28054			
			IIA, NC 20034	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
170		,	IAG	DEFICIENCY)		
V 112	Continued From page	e 16	V 112			
	This Dula is makesat	an avidamend by				
	This Rule is not met					
		nd record review, the facility				
	failed to develop and					
	strategies to meet the					
		ed current clients (Clients #1,				
	,	2 audited former clients				
	(Former Client #4). T	he findings are:				
	Review on 2/8/22 of 0	Client #1's record revealed:				
	-Admitted 10/21/20;					
	-Diagnosed with Con-	duct Disorder, Obsessive				
	Compulsive Disorder	, Unspecified Trauma or				
	Stressor Related Disc	order;				
	-16 years old;					
	-Treatment Plan date	d 1/12/22 did not include				
		sexualized behaviors.				
	_	te on 11/17/21 revealed				
	Client #1 had "been a					
		odate on 1/12/22 revealed				
		writing sexually inappropriate				
	letters to another pee					
	Review on 2/8/22 of (	Client #2's record revealed:				
	-Admitted 6/3/21;	onent #2 e recera revealea.				
	,	t-Traumatic Stress Disorder,				
		sorder, Attention Deficit				
	Hyperactivity Disorde					
	-14 years old;	:1,				
	_	d 12/20/21 did not include				
		d 12/30/21 did not include				
	strategies to address	sexualized behaviors.				
	Di	06				
		Client #3's record revealed:				
	-Admitted 1/18/22;					
		uptive Mood Dysregulation				
	Disorder, Post-Traum					
	Attention Deficit Hype	eractivity Disorder, Other				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL036-337	B. WING		R <b>02/17/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE	508 N RA	NSOM STREET		
		GASTON	IA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 17	V 112		
V 112	Reactions to Severe 1-13 years old; -Treatment Plan date strategies to address  Review on 2/8/22 of Frecord revealed: -Admitted 9/29/21; -Discharged 1/26/21; -14 years old; -Diagnosed with Post Attention Deficit Hype Oppositional Defiant Explosive Disorder; -Treatment Plan date strategies to address AWOL (absent without Review on 2/10/22 arunsigned handwritten -First set of letters (to of a sexual interactions be reviewed on 2/10/22; -Second set of letters one-sided) of a sexual in writers was reviewed	Stress; d 1/7/22 did not include sexualized behaviors. Former Client #4's (FC#4)  -traumatic Stress Disorder, eractivity Disorder, Disorder, Intermittent d 1/17/22 did not include sexualized behaviors or ut leave).  and 2/15/22 of undated and eletters revealed: taling 13 pages one-sided) erincluding requests for etween the writers was (totaling 6 pages alized nature including teractions between the on 2/15/22.  the facility's Incident Reports 1/8/22 revealed:	V 1112		
	=	avior made by FC#4 against			
	-Clients #1 and #3 wr to each other;	with Staff #1 revealed: ote letters of a sexual nature uring Client #3 to engage in			

Division of Health Service Regulation

STATE FORM 6899 D4PS11 If continuation sheet 18 of 79

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  508 N RANSOM STREET  GASTONIA, NC 28054		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL036-337   B. WING				A. BUILDING: _			
SERENITY HOUSE 508 N RANSOM STREET GASTONIA, NC 28054			MHL036-337	B. WING		R 02/17/2022	2
SERENITY HOUSE  GASTONIA, NC 28054	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
	SERENIT	Y HOUSE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO		(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE APPROP	D BE COMF	(5) PLETE ATE
V 112  Continued From page 18 sexualized behaviors.  Interview on 2/16/22 with Staff #2 revealed: -Clients #1 and #3 wrote letters of a sexual nature to each other.  Interview on 2/16/22 with Staff #3 revealed: -Clients #1 and #3 wrote letters of a sexual nature to each otherThe letters were found by Staff #4 or Staff #6 during the weekend of 2/5/22-2/6/22; -Notified Licensee-Qualified Professional #2 (L-QP#2) of the letters on 2/7/22.  Interview on 2/16/22 with Staff #4 revealed: -Discovered Clients #1 and #3 wrote letters of a sexual nature to each other on a about 2/3/22 and notified her supervisor (Staff #3); -Had observed Client #1 engage in grooming behaviors with other clients and had redirected her; -Did not have training regarding sexually aggressive youth from this job placement but had training from previous employment; -"[Client #1] can be very manipulative and slickwants to put her hands on others"  Interview on 2/14/22 with Staff #6 revealed: -Clients #1 and #3 wrote letters of a sexual nature to each other; -Client #1 displayed sexually explicit behaviors for the past several weeks.  Interview on 2/16/22 with Qualified Professional #1 (QP#1) revealed: -Client #1 reported sexual urges over one year ago; -Client #1 wrote letters of a sexual nature to Former Client #4. The letters were found and	V 112	sexualized behaviors  Interview on 2/16/22 -Clients #1 and #3 wr to each other.  Interview on 2/16/22 -Clients #1 and #3 wr to each other; -The letters were four during the weekend of -Notified Licensee-Qu (L-QP#2) of the letter  Interview on 2/16/22 -Discovered Clients # sexual nature to each and notified her supe -Had observed Client behaviors with other of her; -Did not have training aggressive youth from training from previous -"[Client #1] can bewants to put her ha  Interview on 2/14/22 -Clients #1 and #3 wr to each other; -Client #1 displayed s the past several weel  Interview on 2/16/22 #1 (QP#1) revealed: -Client #1 reported se ago; -Client #1 wrote letter	with Staff #2 revealed: rote letters of a sexual nature  with Staff #3 revealed: rote letters of a sexual nature  and by Staff #4 or Staff #6 of 2/5/22-2/6/22; ualified Professional #2 or on 2/7/22.  with Staff #4 revealed: thand #3 wrote letters of a rother on or about 2/3/22 rvisor (Staff #3); with engage in grooming clients and had redirected or regarding sexually or this job placement but had as employment; we very manipulative and slick ands on others"  with Staff #6 revealed: rote letters of a sexual nature sexually explicit behaviors for as.  with Qualified Professional exual urges over one year are of a sexual nature to	V 112			

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DIVISION	of Health Service Regu	liation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	COMPLE		(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL036-337	B. WING		
		WITLU36-337			02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		508 N RA	ANSOM STREET		
SERENITY	/ HOUSE		IIA, NC 28054		
			IIA, NO 20034	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( -/
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
1710		,	1,7.0	DEFICIENCY)	
V 112	Continued From page	e 19	V 112		
	the letters;				
	,	rs of a sexual nature to			
		were found approximately			
	two weeks ago;	were round approximately			
	•	#2 had gotten into her bed			
	and touched her in a				
		ervices were secured for			
		er sexualized behaviors			
		ation to remain at the facility			
	ends 2/24/22;				
		ervices were secured for			
		er sexualized behaviors			
		duled to discharge soon;			
		ervices were secured for			
	FC#4 regarding her s				
	-Completed virtual vis				
		ner work from the office;			
		ents were in school and only			
	saw the clients virtual				
	-Did not meet with the	e LP for clinical supervision.			
	lti	0/40/00 0/45/00			
		2/10/22 and 2/15/22 with the			
	L-QP#2 revealed:	0/0/00 (1 D: : : (			
		on 2/8/22 after Division of			
	Health Service Regul	•			
		regarding letters of a			
	sexual nature written				
		s was written between			
		d were discovered during the			
	weekend of 2/5/22-2/				
		tters was written between			
	Client #1 and FC#4;				
		1 to develop treatment plan			
	strategies to address				
	behaviors and AWOL	. <b>.</b>			
		itutes a re-cited deficiency.			
		een cited three times on			
	7/29/19, 10/3/19, and	l 6/10/21.			

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENIT	/ HOUSE		NSOM STREET		
	CLIMMADY CT		A, NC 28054	DROVIDEDIC DI AM OF CODDECTIO	N
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 112	Continued From page	20	V 112		
	NCAC 27G .1701 Sco	es referenced into 10A ope (V293) for a Type A1 of be corrected within 23			
V 117	27G .0209 (B) Medica	ation Requirements	V 117		
	visible; (2) Prescription med or obtained as sample tamper-resistant pack risk of accidental inge packaging includes pl with tamper-resistant unit-of-use packaged may be adequate; (3) The packaging ladrug dispensed must (A) the client's name (B) the prescriber's name (C) the current dispe (D) clear directions for (E) the name, streng date of the prescribed (F) the name, address	ging and labeling: drug containers not nacist shall retain the with expiration dates clearly ications, whether purchased es, shall be dispensed in raging that will minimize the estion by children. Such astic or glass bottles/vials caps, or in the case of drugs, a zip-lock plastic bag bel of each prescription include the following: ;; name; nsing date; or self-administration; th, quantity, and expiration I drug; and es, and phone number of the ng location (e.g., mh/dd/sa			

Division of Health Service Regulation

STATE FORM 6899 D4PS11 If continuation sheet 21 of 79

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BOILDING			R
		MHL036-337	B. WING			17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SERENIT	Y HOUSE		ANSOM STREET			
	OLIMA BY OT		IIA, NC 28054	DDOV/DEDIO DI ANA	OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 117	Continued From page	e 21	V 117			
	client's and prescribe and location, name, s medication and expirations for administ audited clients (Client Observation on 2/7/2 of Client #2's medication of Triamcinolor disorder) with a worn Review on 2/8/22 of C-Admitted 6/3/21; -Diagnosed with Post Major Depressive Dis Hyperactivity Disorder -14 years old.	ecord review, and ty failed to ensure all d packaging labels with r's name, dispensing date strength, quantity of ation date, and clear stration affecting 1 of 3 t #2). The findings are: 2 at approximately 12:15pm tion revealed: ne Cream 0.1% Cream (skin label with no visible print. Client #2's record revealed: t-Traumatic Stress Disorder, corder, Attention Deficit				
		ted 6/4/21 for Triamcinolone as apply to affected area 3				
	Professional #2 (L-QI Manager revealed: -The writing on the pl Triamcinolone Cream no longer be read; -Will arrange to have Interview on 2/15/22	narmacy label of Client #2's n 0.1% was worn and could				

Division of Health Service Regulation

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE	
						R
		MHL036-337	B. WING		02/	17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SERENIT	Y HOUSE		ANSOM STREET			
			NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 117	Continued From pag	e 22	V 117			
	legible.					
	This deficiency has b	peen cited two times on 9.				
	NCAC 27G .0209 Me	ess referenced into 10A edication Requirements rule violation and must be ays.				
V 118	27G .0209 (C) Medic	cation Requirements	V 118			
	only be administered order of a person aut drugs.  (2) Medications shall clients only when aut client's physician.  (3) Medications, incluadministered only by unlicensed persons to pharmacist or other I privileged to prepare (4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name;  (B) name, strength, and (C) instructions for and (D) date and time the (E) name or initials or drug.	be self-administered by thorized in writing by the licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. Ininistration Record (MAR) of the total tot				

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Division of Health Service Regulation

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		\ , ,	SURVEY PLETED
		MHL036-337	B. WING		02	R 2/ <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
CEDENIT	/ UOU0E	508 N RA	ANSOM STREET			
SERENIT	HOUSE	GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 23	V 118			
	checks shall be recor	ded and kept with the MAR pointment or consultation				
	order of a person aut medications and faile	ecord review, and ty failed to ensure ministered on the written horized by law to prescribe d to keep MARs current ed clients (Clients #1, #2,				
	Medication Requirem Based on interview, r observation, the facili medications containe client's and prescribe and location, name, s medication and expire	ecord review, and ty failed to ensure all d packaging labels with r's name, dispensing date strength, quantity of ation date, and clear tration affecting 1 of 3				
	Medication Requirem Based on interview, r observation, the facili and external medicat and failed to ensure saffecting 1 of 3 audited	ecord review, and ty failed to ensure internal ions were stored separately safe storage of medications ed clients (Client #2).  E: 10A NCAC 27G .0209				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		D	
		MHL036-337	B. WING	B. WING		R <b>17/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓΕ, ZIP CODE			
SERENITY	/ HOUSE	508 N RA	NSOM STREET				
		GASTON	IA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	e 24	V 118				
	administration errors reactions and report t pharmacist affecting 3 (Clients #1, #2, and #	ty failed to record drug and significant adverse drug them to a physician or 3 of 3 audited clients 3).					
	Review on 2/7/22 and 2/10/22 of Client #1's medication orders revealed:  -No start or stop order for Low-Ogestrel-28;  -Medication order dated 9/20/21 for Guanfacine HCL 3mg 1 tab each evening;						
	-No order for time change for Guanfacine HCL 3mg 1 tab at 4pm; -Several hours past the deadline set by DHSR (Division of Health Service Regulation) survey staff for submission of medication orders, Licensee-Qualified Professional #2 (L-QP#2) provided copies of unsigned escribe orders dated 12/10/21 for Low-Ogestrol-28 but was unable to provide a discontinue order and 1/19/22 for Guanfacine HCL 3mg 1 tab daily at 4pm.						
	and January and Feb -No listing of Low-Og -Guanfacine HCL (Atl Disorder (ADHD)) 3m at 7pm on the Decem	g 1tab from 1/1/22-1/25/22 n 7pm to 4pm from					
	of Client #1's medicat -Low-Ogestrel-28 1 ta -Guanfacine HCL 3m 1/25/22.	2 at approximately 12:25pm tion revealed: ab daily dispensed 12/10/21; g 1 tab at 4pm dispensed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL036-337 B. WING			R <b>02/17/2022</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	FE, ZIP CODE		
SERENITY HOUSE		NSOM STREET IA, NC 28054			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
30 minutes prior to -No start or stop of every morning; -Medication order HCL 20mg 3 tabs the administration -Several hours passurvey staff for sullabel L-QP#2 provided orders for Clonidi but was unable to Fluoxetine 40mg was unable to professional programme and -No listing of Ome caplet (cap) cap of -No listing of multidaily on the Februs -Clonidine (ADHE before bedtime and then discontinued -Fluoxetine (antid morning administration discontinued on the -Fluoxetine HCL 2 the December MA Observation on 2 of Client #2's med -No Clonidine 0.1 -No Fluoxetine 40 -Fluoxetine HCL 2 1/10/22; -Multivitamin 1 tal	s revealed: order for Clonidine 0.1mg 1 tab o bedtime; order for Fluoxetine 40mg 1 tab dated 1/5/22 for Fluoxetine but no order prior to 1/5/22 for of the medication; st the deadline set by DHSR bmission of medication orders, copies of unsigned escribe ne 0.1mg daily dated 11/23/21 provide a discontinue order, 1 tab daily dated 11/23/21 but vide a discontinue order, 20 tabs dated 12/16/21.  of Client #2's December, 2021 February, 2022 MARs revealed: prazole (heartburn) 20mg 1 laily on the December MAR; invitamin (supplement) 1 tab lary MAR; 0) 0.1mg 1 tab 30 minutes diministered 12/1/21-12/19/21 on the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR; epressant) 40mg 1 tab every ered 12/1/21-12/20/21 then the December MAR;	V 118	DEFICIENCY)		

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE S	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			-		_	_
			D MINO		1	₹
MHL036-337		B. WING		02/1	17/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIP CODE		
			NSOM STREET	•		
SERENITY	/ HOUSE					
		GASTONI	A, NC 28054	1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	NEGOLATORT OR I	100 IDENTIFY THE INTO ONNIATION)	TAG	DEFICIENCY)	JI NAIL	
			+			
V 118	Continued From page	e 26	V 118			
	0/0000					
	6/2023.					
	Attampted review on	2/10/22 of Client #2!a				
	Attempted review on					
	medication orders rev					
	medication orders at					
		e deadline set by DHSR				
	-	ssion of medication orders,				
	L-QP#2 provided cop	ies of unsigned escribe				
	orders for:					
	-Concerta 36mg	1 tab every morning dated				
	1/27/22,					
	-Ziprasidone HCl	L 20mg 1 cap every morning				
	dated 1/27/22,					
	-Ziprasidone HCI	L 60mg 1 cap every evening				
	dated 1/27/22,					
		).3mg take 1 tab every				
	evening dated 1/27/2	-				
	•	ong 2 ½ tabs every morning				
	dated 1/25/22,	mg 2 /2 tabe every merming				
	•	1 tab every evening dated				
	1/25/22,	r tab every everning dated				
	•	mg 1 tab every morning				
	dated 1/27/22,	mig i tab every morning				
	•	L 50mg 1 tab every evening				
	dated 1/25/22,	L Sollig 1 tab every everiling				
	,	latonin 2mg 1 can ayarı				
		elatonin 3mg 1 cap every				
	evening;	f D-h 0.50/				
		rs for Debrox 6.5% ear				
	drops 5 drops into ea	cn ear.				
	Davious on 0/7/00 -50	Client #2's January and				
		Client #3's January and				
	February, 2022 MARs	s revealed:				
	-Administration of:	2) 22				
	· ·	D) 36mg 1 tab every				
	morning,					
	•	L (antipsychotic) 20mg 1 cap				
	every morning,					
	-Ziprasidone HCl	L 60mg 1 cap every evening,				
	-Melatonin (sleep	o) 3mg 1 tab every evening,				

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-Clonidine HCL 0.3mg 1 tab every evening,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				<del></del>	R	
		MHL036-337	B. WING		02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE		
SERENIT	Y HOUSE		ANSOM STREET			
	T		IIA, NC 28054		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPI	LETE
V 118	Continued From page	e 27	V 118			
	-Cetirizine (allergevening, -Escitalopram (devery morning, -Hydroxyzine HCevery evening; -Lamotrigine (momorning on the Janual-Lamotrigine 200 every morning on the Janual-Lamotrigine 200 every assistant as Janual-Lamotrigine 41/5/22; -Ziprasidone HCL 200 Ziprasidone HCL 60n Melatonin 3mg 1 cap HCL 0.3mg take 1 tat 100mg 2 ½ tabs ever 1 tab every evening dispensed 10mg, every morning, Hydroevery evening dispensed 11/23/21.  Interviews on 2/16/22 revealed: -Did not have access administering medical-Lamotrigine 200 every morning, Hydroevery evening dispensed 11/23/21.  Interviews on 2/16/22 revealed: -Did not have access administering medical-Lamotrigine 200 every evening dispensed 11/23/21.	epression) 120mg 1 tab CL (hyperkinesis) 50mg 1 tab CL (hyperkinesis) 50mg 1 tab COOD 100mg 2 ½ tabs every COOD 100mg 2 ½ tabs COOD 100mg 2 ½				

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set by DHSR survey staff of 2/10/22 at 10am and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		
		A. BUILDING:			PLETED
MHL036-337		B. WING		02	R 2/ <b>17/2022</b>
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE	·	
	508 N RA	ANSOM STREET			
SERENITY HOUSE		IIA, NC 28054			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
because she was expressings while taking the Client #3 came to the ear drops but they well-bid not have any medif Client #3's Debrox 6 be administered or if the Will ensure all start at are maintained at the Will ensure all MARs future.  Due to the failure to admedication administrated determined if clients reas ordered by the phys.  This deficiency constitt This deficiency has be 7/29/19, 10/3/19, and Review on 2/15/22 of (POP) written and signt L-QP#2 revealed:  "What immediate actice ensure the safety of the Describe your plans to happens.  V120/V123: All internationare now stored separatincident reports if there V117: Staff will ensure are legible and are in V118: Staff will obtain medication orders to separations.	esult in a citation; strol-28 was discontinued eriencing severe mood e medication; a facility with Debrox 6.5% re not administered; dication orders to determine 6.5% ear drops needed to hey were discontinued; nd stop medication orders facility in the future; are kept current in the ccurately document attion it could not be eccived their medications sician.  Itutes a re-cited deficiency. Each cited three times on 6/10/21.  Ithe first Plan of Protection and on 2/15/22 by the consumers in your care? To make sure the above all and external medications ately. Staff will complete e are medication errors. It is all labels on medications and store at the office or group ays (Licensee) is in the	V 118			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. Boilbing.		D
		MHL036-337	B. WING		R 02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENITY	HOUSE		ISOM STREET A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	obtained. Pathways Director willicensed professional, effective 2/21/22 to more received and professional, effective 2/21/22 to more received and professional, effective 2/21/22 to more received and professional reports if the pathways Group Hone [consulting licensed professional] effective corrections are being V117: Staff will ensure are legible and are in new label was obtaine 2/7/22. Pathways Growith [consulting licensed professional] effective corrections are being V118: Staff will obtain medication orders to shome facilities. Pathways Growith in glients to [lot one sure that orders discontinued orders to switch will happen no Pathways Group Hone [consulting licensed professional] effective corrections are being licensed professional] effective corrections are being	Il meet with [consulting /qualified professional] take all corrections."  If the second POP written and the L-QP#2 revealed: on will the facility take to the consumers in your care? on make sure the above  all and external medications tately. Staff will complete the are medication errors. The Director will meet with the professional/qualified to 2/21/22 to ensure all the made weekly. The all labels on medications the facility at all times. A tend for the cream effective to the professional/qualified to 2/21/22 to ensure all the made weekly. The professional/qualified to 2/21/22 to ensure all made weekly. The professional design and the professional and the store at the office or group ways is in the process of the professional and the professional and the later than 3/15/22. The Director will meet with professional/qualified to 2/21/22 to ensure all	V 118		
		the L-QP#2 revealed:			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
74101 12744	or connection	ISENTI IS WISH NOMBER.				PLETED
		MHL036-337	B. WING		02	R 2/ <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			ANSOM STREET			
SERENIT	Y HOUSE		IIA, NC 28054			
	CUMMA DV CT		·	DDOV/DEDIC DI ANI OF CO	DDDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 30	V 118			
	"What immediate acti	on will the facility take to				
		he consumers in your care?				
	_	o make sure the above				
	happens.	o make date the above				
		al and external medications				
		ately. Staff will complete				
		re are medication errors.				
	-	ne Director will meet with				
	[consulting licensed p					
	professional] effective	e 2/21/22 to ensure all				
	corrections are being	made weekly.				
	V117: Staff will ensur	e all labels on medications				
	_	the facility at all times. A				
		ed for the cream effective				
	_	oup Home Director will meet				
		sed professional/qualified				
	_	e 2/21/22 to ensure all				
	corrections are being	-				
	V118: Staff will obtain					
		store at the office or group vays is in the process of				
		ocal mental health provider]				
		are always present and that				
		an also be obtained. The				
	switch will happen no					
		ne Director will meet with				
	[consulting licensed p					
		e 2/21/22 to ensure all				
	corrections are being					
	Clients #1. #2. and #3	3 ranged in age from 13-16				
		diagnosed with a variety of				
		including, but not limited to,				
	Attention Deficit Hype	<b>.</b>				
	Post-Traumatic Stres					
	Disorder, Obsessive	Compulsive Disorder, Major				
	Depressive Disorder,	and Disruptive Mood				
	Dysregulation Disorde	er. Medication orders were				
		w despite Clients #1, #2,				
	and #3 receiving med	lications. Due to the lack of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE ZIP CODE	
	10115211 011 001 1 21211		ISOM STREET	, 2 3332	
SERENITY	/ HOUSE		A, NC 28054		
			·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 31	V 118		
	medication orders it of Client #1's birth control #2's Fluoxetine was in should be using ear of administration records several medications in control and Guanfacin and multivitamin, and Client #2's internal me external medications Cream). Medications evidenced of a loose medication box. Client Cream did not have a documentation of any adverse medication receiving birth control constitutes a Type A1 neglect and must be a An administrative per imposed. If the violate 23 days, an additiona \$500.00 per day will be	could not be determined if ol was discontinued, Client increased, or if Client #3 drops. Medication is were not kept current for including Client #1's birth ine, Client #2's Omeprazole Client #3's Lamotrigine. edications were stored with (Triamcinolone 0.1% was not stored securely as pill present in Client #2's int #2's Triamcinolone 0.1% in legible label. There was now medication errors or any eactions despite reports of g mood swings while in pills. This deficiency rule violation for serious corrected within 23 days.			
V 120	27G .0209 (E) Medica	ation Requirements	V 120		
	and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degree refrigerator is used fo	ie: all be stored: ed cabinet in a clean, d room between 59 degrees enheit; required, between 36			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
741012741	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING:		
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENIT	/ HOUSE		SOM STREET		
			A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 120	(E) in a secure manner for a client to self-med (2) Each facility that no controlled substances registered under the N	ch client; ernal and internal use; er if approved by a physician dicate. naintains stocks of s shall be currently North Carolina Controlled 90, Article 5, including any	V 120		
	and external medicati and failed to ensure s affecting 1 of 3 audite findings are:  Review on 2/8/22 of C -Admitted 6/3/21; -Diagnosed with Post Major Depressive Dis Hyperactivity Disorde -14 years old.  Finding #1 Observation on 2/7/22 of Client #2's medicat -Tube of Triamcinolor disorder) stored with in Interviews on 2/7/22 of Professional #2 (L-QF (HM) revealed:	ecord review, and ty failed to ensure internal ons were stored separately eafe storage of medications ed clients (Client #2). The Client #2's record revealed:  -Traumatic Stress Disorder, order, Attention Deficit r;  2 at approximately 12:15pm cion revealed: ne Cream 0.1% Cream (skin			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL036-337		B. WING		02	R 2/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	·	
SERENITY	/ HOUSE	508 N R	ANSOM STREET			
SERENIII	HOUSE	GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 120	Continued From page	33	V 120			
	and ensure they are s future.	stored separately in the				
	of Client #2's medical -Loose pill in the botte similar to those in a b packaging label date medication as Fluoxe 20mg.  Interviews on 2/7/22 or revealed: -Could not identify if the blister pack or if it wa administered to Clien administration; -Could not identify ho the bottom of the medical	om of the medication box lister pack with pharmacy d 1/10/22 identifying the tine HCL (antidepressant)  with L-QP#2 and HM  the loose pill fell from the s supposed to be t #2 during medication  w long the loose pill was in				
	immediately.  Interview on 2/15/22 -Would ensure all me	with the L-QP#2 revealed:				
	NCAC 27G .0209 Me	ss referenced into 10A dication Requirements rule violation and must be ays.				
V 123	27G .0209 (H) Medic	ation Requirements	V 123			
		O MEDICATION  Drug administration errors see drug reactions shall be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENIT	/ HOUSE		NSOM STREET A, NC 28054		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	NI (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 123	Continued From page	e 34	V 123		
	reported immediately pharmacist. An entry and the drug reaction				
	administration errors reactions and report to pharmacist affecting and (Clients #1, #2, and #1). Review on 2/8/22 of and 40-Admitted 10/21/20; -Diagnosed with Conference of the conference of t	ecord review, and ty failed to record drug and significant adverse drug them to a physician or 3 of 3 audited clients 3). The findings are: Client #1's record revealed: duct Disorder, Obsessive Unspecified Trauma or			
	-Admitted 6/3/21; -Diagnosed with Post	Client #2's record revealed: -Traumatic Stress Disorder, order, Attention Deficit r;			
	-Admitted 1/18/22; -Diagnosed with Disru Disorder, Post-Traum	eractivity Disorder, Other			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL036-337	B. WING		R <b>02/17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CEDENITY	/ HOUSE	508 N RAN	ISOM STREET		
SERENIT	HOUSE	GASTONIA	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 123	Continued From page	e 35	V 123		
	-13 years old.				
	for period 11/1/21 - 2/ -No documentation of				
	Professional #2 and H -Client #1's Low-Oged discontinued because severe mood swings -Could not identify if the medication box fell frow was supposed to be a during medication and the bottom of the medication and the same to the same and the sa	w long the loose pill was in dication box; e facility with Debrox 6.5% ere not administered; dication orders to determine 6.5% ear drops needed to they were discontinued; nentation of any medication or significant adverse drug y but would make sure to			
	of Client #2's medicated -Loose pill in the botton similar to those in a begackaging label dated				
	This deficiency has b 7/29/19, 10/3/19, and	een cited three times on 12/18/19.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENITY	HOUSE		SOM STREET , NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 123	Continued From page	<del>2</del> 36	V 123		
	This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.				
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131		
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.				
	failed to access the H Registry (HCPR) prio	nd record review, the facility			
	Review on 2/14/22 of -Hired 9/29/21; -No documentation of	Staff #4's record revealed: f HCPR review.			
	-Not sure why there w completed on Staff #4 -Would ensure HCPR	rofessional #2 revealed: vas no HCPR review			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE		SOM STREET		
			NC 28054		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 131	Continued From page	37	V 131		
	the future.				
	This deficiency has b 7/29/19 and 2/19/21.	een cited two times on			
	NCAC 27G .1701 Sco	es referenced into 10A  ppe (V293) for a Type A1  st be corrected within 23			
V 133 G.S. 122C-80 Criminal History Record Check		al History Record Check	V 133		
	G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.  (a) Definition As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.  (b) Requirement An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	IRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			B. WING		R	
		MHL036-337	D. WING		02/17	//2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		508 N R	ANSOM STREET			
SERENITY	/ HOUSE		IIA, NC 28054			
			HA, 140 20004			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
V 400	0 " 15	0.0	1/400			
V 133	Continued From page	9 38	V 133			
	section. Except as other	nerwise provided in this				
		e business days of making				
		of employment, a provider				
		t to the Department of				
	Justice under G.S. 11					
		d check required by this				
		it a request to a private				
		ate criminal history record				
	•					
		s section. Notwithstanding Department of Justice shall				
		•				
		ational criminal history				
		ployment positions not				
	covered by Public La					
	•	and Human Services,				
	Criminal Records Che					
		eipt of the national criminal				
	•	the Department of Health				
	· ·	, Criminal Records Check				
		provider as to whether the				
		may affect the employability				
		case shall the results of the				
		ory record check be shared				
	-	viders shall make available				
	· ·	tion that a criminal history				
	•	oleted on any staff covered				
		nty that has adopted an				
		nance and has access to				
		al Information data bank				
	-	ılf of a provider a State				
	_	d check required by this				
		ovider having to submit a				
		ment of Justice. In such a				
	case, the county shal	I commence with the State				
	criminal history record	d check required by this				
	section within five bus	siness days of the				
	conditional offer of en	nployment by the provider.				
	All criminal history inf	ormation received by the				
		al and may not be disclosed,				

Division of Health Service Regulation

except to the applicant as provided in subsection

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		MHL036-337	B. WING		02/1	7/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE	508 N RAN	SOM STREET			
GASTONIA		GASTONIA	, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 133	Continued From page	e 39	V 133			
V 133	(c) of this section. For subsection, the term 'business regularly en criminal history record records obtained from (c) Action If an application a relevant offense, the of the following factor hire the applicant: (1) The level and serie (2) The date of the criminal history recording the perconviction. (4) The circumstance commission of the criminal filled. (6) The prison, jail, properson since the date (7) The subsequent carelevant offense. The fact of conviction shall not be a bar to elisted factors shall be If the provider may disclose the criminal history research.	r purposes of this  'private entity" means a gaged in conducting d checks utilizing public n a State agency. icant's criminal history one or more convictions of e provider shall consider all s in determining whether to  ousness of the crime. ime. rson at the time of the s surrounding the me, if known. en the criminal conduct of b duties of the position to be obation, parole, iployment records of the the crime was committed. ommission by the person of of a relevant offense alone employment; however, the considered by the provider. lifies an applicant after elevant factors, then the enformation contained in cord check that is relevant by but may not provide a copy	V 133			
	(d) Limited Immunity. or employee of a prov	- A provider and an officer vider that, in good faith, ction shall be immune from provider to employ an				

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Division	of Health Service Regu	lation			<del>,</del>
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		MHL036-337	D. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
			, ,	,	
SERENITY	Y HOUSE		NSOM STREET		
		GASTON	IA, NC 28054		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(7.0)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATURT UR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	MATE
				,	
V 133	Continued From page	e 40	V 133		
		s of information provided in			
	•	cord check of the individual.			
	(2) Failure to check a	n employee's history of			
	criminal offenses if th	e employee's criminal			
	history record check i	s requested and received in			
	compliance with this	section.			
	(e) Relevant Offense.	As used in this section,			
	"relevant offense" me	ans a county, state, or			
	federal criminal histor	y of conviction or pending			
	indictment of a crime,	whether a misdemeanor or			
		on an individual's fitness to			
		r the safety and well-being of			
		ntal health, developmental			
		nce abuse services. These			
		minal offenses set forth in			
		rticles of Chapter 14 of the			
		icle 5, Counterfeiting and			
	Issuing Monetary Sub				
	, ,	ve and Legislative Officers;			
		article 7A, Rape and Other			
		8, Assaults; Article 10,			
		ction; Article 13, Malicious			
	Injury or Damage by				
		Material; Article 14, Burglary			
	· ·	akings; Article 15, Arson and			
		0 ,			
		le 16, Larceny; Article 17,			
		Embezzlement; Article 19,			
	False Pretenses and	· · · · · · · · · · · · · · · · · · ·			
		Services by False or			
		edit Device or Other Means;			
	·	Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against				
		, Adult Establishments;			
		n; Article 28, Perjury; Article			
	, , , , , , , , , , , , , , , , , , , ,	, Misconduct in Public			
		enses Against the Public			
		iots and Civil Disorders;			
	Article 39, Protection	of Minors; Article 40,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2 . 2.1.		152.1111.107.111011.110.11152.11	A. BUILDING: _			
		MHL036-337	B. WING		R <b>02/17/2022</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SERENITY	/ HOUSE	508 N RA	ANSOM STREET			
OLINLINI		GASTON	IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
V 133	V 133 Continued From page 41		V 133			
	Protection of the Fam Intoxication; and Artic Crime. These crimes sale of drugs in violati Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 18B-impaired in violation of G.S. 20-138.5.  (f) Penalty for Furnish applicant for employment applic criminal history record shall be guilty of a Cla (g) Conditional Employment applicant obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4,	illy; Article 59, Public le 60, Computer-Related also include possession or ion of the North Carolina is Act, Article 5 of Chapter tutes, and alcohol-related to underage persons in 302 or driving while of G.S. 20-138.1 through the formation on cation that is the basis for a dicheck under this section ass A1 misdemeanor. Syment A provider may conditionally prior to of a criminal history record applicant if both of the sare met:  not employ an applicant applicant applicant's consent for dicheck as required in section or the completed equired in G.S. 114-19.10. Submit the request for a dicheck not later than five the individual begins ent. (2000-154, s. 4; 124, ss. 10.19D(c), (h); 5(a); 2007-444, s. 3.)				
	This Rule is not met a	as evidenced by: nd record review, the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION	
			A. BUILDING: _	A. BUILDING:	
MHL036-337 B. WING				02/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		508 N R	ANSOM STREET		
SERENITY	/ HOUSE		NIA, NC 28054		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 133	Continued From page	e 42	V 133		
	failed to request a crir	minal background check			
	within five days of an				
		ted staff (Staff #2, #4, and			
	#6). The findings are				
		Staff #2's record revealed:			
	-Hired 9/29/21; -No criminal backgrou	ind check requested			
	-No chiminal backgrot	and check requested.			
	Review on 2/14/22 of	Staff #4's record revealed:			
	-Hired 9/29/21;				
	-Criminal background	check requested 2/14/22.			
	Davious on 2/14/22 of	Staff #6's record revealed:			
	-Hired 10/9/21;	Stall #05 record revealed.			
		check requested 12/27/21.			
	Interviews on 2/10/22	and 2/15/22 with the			
		ofessional #2 revealed:			
	-Did not yet request a	criminal background check			
	on Staff #2 as she wa	s recently hired;			
	_	iminal background checks			
	-	or Staff #4 and #6 but could			
	not identify the reason				
		al background checks be			
	requested within 5 da				
	employment in the fut	ure.			
	This deficiency has be	een cited two times on			
	7/29/19 and 2/19/21.				
		ss referenced into 10A			
		ope (V293) for a Type A1			
		st be corrected within 23			
	days.				
	070 4704 5 11 11	I.T. O. 11.1/A. I. I. O.			
V 293	2/G .1/01 Residentia	al Tx. Child/Adol - Scope	V 293		
	10A NCAC 27G .170	1 SCOPE			

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STATE FORM D4PS11 If continuation sheet 43 of 79

Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					<sub>D</sub>
		MUL 026 227	B. WING		R
		MHL036-337	B: WiiNO		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		508 N RA	NSOM STREET		
SERENITY HOUSE		IA, NC 28054			
			IA, NC 20034	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
			1.,		
V 293	Continued From page	e 43	V 293		
	(a) A residential treat	tment staff secure facility for			
	children or adolescen	-			
		tial facility that provides			
	intensive, active thera				
		system of care approach. It			
		ary residence of an individual			
	who is not a client of				
		ns staff are required to be			
	` ,	leep hours and supervision			
	•	s set forth in Rule .1704 of			
	this Section.	3 3Ct lotti ili itale . 1704 oi			
		erved shall be children or			
		e a primary diagnosis of			
	mental illness, emotion				
		sorders; and may also have			
		s including developmental			
	•	nildren or adolescents shall			
		npatient psychiatric services.			
		dolescents served shall			
	require the following:	dolescents served shall			
	-	m home to a			
	` '	sidential setting in order to			
	facilitate treatment; a	<del>-</del>			
		n a staff secure setting.			
	(e) Services shall be	•			
		vidualized supervision and			
	structure of daily livin				
		e occurrence of behaviors			
	related to functional of				
		ety and deescalate out of			
	control behaviors incl				
		without physical restraint;			
	•	hild or adolescent in the			
	` '	e functioning in self-control,			
		al and recreational skills; and			
		child or adolescent in			
		ded to step-down to a less			
	intensive treatment se	The state of the s			
	(i) The residential tre	eatment staff secure facility	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		MHL036-337	B. WING		R <b>02/17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDENITY	/ HOUSE	508 N RAN	SOM STREET		
SERENIT	HOUSE	GASTONIA	, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 293	Continued From page	± 44	V 293		
	shall coordinate with				
	necessary level of supervide intensive supervide intensive supervised from the supervi	ecord review, and ty failed to provide the pervision and structure to ervision, active therapeutic entions with a system of care ed current clients (Clients #1, 2 audited former clients The findings are:  E: 10A NCAC 27G .0202			
	failed to ensure a writ present in each staff i 10 audited staff (Staff Manager) and failed t met the minimum edu	ents (V107) and record review, the facility sten job description was member's file affecting 5 of f #1, #2, #4, #5, and House to ensure each staff member sucation requirements for g 2 of 10 audited staff (Staff			
	Personnel Requirement Based on interview at failed to provide training clients affecting 10 of	E: 10A NCAC 27G .0202 ents (V108) nd record review, the facility ing to meet the needs of the 10 audited staff (Staff #1, buse Manager, Qualified			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDEIVIII IOATION NOMBER.	A. BUILDING: _		
		MHL036-337	B. WING		R 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
SERENITY	Y HOUSE		NSOM STREET A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE
V 293	#2, Licensed Professional CROSS REFERENC Competencies of Quarassociate Professional Based on interview an qualified professional Licensee-Qualified Professional) failed to knowledge, skills, and population served.  CROSS REFERENC Assessment and Treaservice Plan (V111) Based on interview and failed to have strateging of services for 1 of 3 and CROSS REFERENC Assessment and Treaservice Plan (V112) Based on interview and failed to develop and strategies to meet the affecting 3 of 3 audited #2, and #3) and 1 of 20 (Former Client #4).  CROSS REFERENC 131E-256 Health Carabased on interview and failed to access the HRegistry (HCPR) prio affecting 1 of 10 audited CROSS REFERENC 10 audited CROSS REFERENC 10 audited CROSS REFERENC 10 audited CROSS REFERENC 10 audited 10	ensee-Qualified Professional ional).  E: 10A NCAC 27G .0203 alified Professionals and als (V109) and record review, 3 of 3 as (Qualified Professional #1, rofessional #2, and Licensed of demonstrate the disabilities required by the  E: 10A NCAC 27G .0205 atment/Habilitation or and record review, the facility resimples in place prior to delivery resided and clients (Client #2).  E: 10A NCAC 27G .0205 atment/Habilitation or and record review, the facility representation in the facility representation of the clients and current clients (Clients #1, 22 audited former clients  E: General Statute re Personnel Registry (V131) and record review, the facility realth Care Personnel red staff (Staff #4).  E: General Statute 122C-80	V 293		
	Criminal History Reco Based on interview a	ord Check (V133) and record review, the facility			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-337	B. WING		02	R 2/ <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	·	
SERENITY	Y HOUSE		ANSOM STREET NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 293	within five days of an affecting 3 of 10 audi #6).  CROSS REFERENC Requirements of Qua Based on interview a Qualified Professional perform clinical and a a minimum of ten hou of the time when adopresent.  CROSS REFERENC Minimum Staffing Rebased on interview a failed to ensure minimum staff for up to four additional consultation of the time when adopresent.  CROSS REFERENC Requirements of Lice Based on interview a Licensed Professional to face clinical consultation week.  CROSS REFERENC Incident Response Reand B Providers (V36) Based on interview a failed to implement the reporting.	minal background check offer of employment ted staff (Staff #2, #4, and E: 10A NCAC 27G .1702 lified Professionals (V294) and record review, the I #1 (QP#1) failed to dministrative responsibilities are each week at least 70% escents were awake and E: 10A NCAC 27G .1704 quirements (V296) and record review, the facility num staffing ratios of two olescents.  E: 10A NCAC 27G .1705 ansed Professionals (V297) and record review, the li (LP) failed to provide face tation at least four hours  E: 10A NCAC 27G .0603 equirements for Category A 6) and record review, the facility and record review, the facility	V 293	BETTOLENE		
	and B Providers (V36 Based on interview a failed to notify the loc	equirements for Category A 7) nd record review, the facility al management entity of all in 72 hours of becoming				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION			
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING:	A. BUILDING:		PLETED
						R
		MHL036-337	B. WING		02	/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		508 N RA	ANSOM STREET			
SERENIT	Y HOUSE	GASTON	IIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 293	Continued From page	e 47	V 293			
	aware of the incidents	S.				
	Location and Exterior Based on interview, r observation, the facili	E: 10A NCAC 27G .0303 Requirements (V736) ecord review, and ty was not maintained in a , and orderly manner.				
	This deficiency has b 7/29/19, 10/3/19, and	een cited three times on 2/17/22.				
	(POP) written and sig Licensee-Qualified Pr revealed:	the first Plan of Protection ined on 2/15/22 by the rofessional #2 (L-QP#2)				
	ensure the safety of t Describe your plans t happens.	on will the facility take to he consumers in your care? o make sure the above (Licensee) Group Homes				
	education are in the f Pathways Group Hon	nat job descriptions and iles of all employees at nes. All staff will be trained if				
	AWOLS (absent with	viors such as sexualized, out leave), etc. Professional #1) will be				
	responsible for assist staffed trained for clie	ing the director in getting ent behaviors. QP will need				
	goals that line up with	lans in accordance with the behaviors of the client. s will be updated to reflect				
		iors. [consulting licensed				
	that treatment plans a	•				
		embers will have nurse aid before their date of hire. checks will also be				
	completed and mainta	ained in the employee's file. mplete 10 hours in the group				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETI	ED	
					R		
		MHL036-337	B. WING		02/17/	2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
		508 N RAN	ISOM STREET				
SERENITY	HOUSE		A, NC 28054				
0(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N	0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 293	Continued From page	÷ 48	V 293				
	home as required. Pa						
	2/15/22 to address all	onference for [QP#1] for					
		ip Homes will continue to					
		neduling that will allow two					
	•	ed on each shift. In the					
	-	all out, there is a proper					
		at will be utilized to ensure					
	that coverage needs						
	V297: The LP (Licens						
	,	n person at the group home					
		le due to COVID exposure.					
	-	e is a COVID exposure, LP					
		via telehealth and not via					
	phone call. [consulting						
	professional/qualified	professional] will be					
	providing oversight ar	nd consultation to ensure					
	that LP meets all requ	uirements.					
		ports will be completed					
	within 72 hours and ir						
	completed for all incid						
	*	ded paper copies of incident					
		n shift when an incident					
	occurs.						
		was a lock on the laundry					
	_	ctor was made aware that					
		ne lock was immediately					
	to discuss getting the	Director will contact landlord					
	V293: Pathways Grou						
	[consulting licensed p	- <del>-</del> -					
		operations to ensure that					
		cted. A Consultation log will					
		ment each time [consulting					
		/qualified professional]					
	provides supervision.	· · · · · · · · · · · · · · · · · · ·					
		I ensure that all needs are					
	-	riate channels in place					
	going forward to ensu						
	decrease in occurrent						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		MHL036-337	B. WING		0.3	R 2/ <b>17/2022</b>
		IMITE030-337			02	11112022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SERENIT	Y HOUSE		ANSOM STREET			
		GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 293	Continued From page	e 49	V 293			
	_	ll meet with [consulting /qualified professional] nake all corrections."				
	signed on 2/15/22 by "What immediate acti ensure the safety of t Describe your plans thappens. V107/108: Pathways ensure that job describe files of all employ Homes by 3/1/22. All exhibits behaviors suetc by 3/15/22. Pathwill meet with [consul professional/qualified 2/21/22 to ensure all weekly. V109: QP will be respondirector in getting starbehaviors. QP will ne	professional] effective corrections are being made consible for assisting the ffed trained for client ed to update treatment plans				
	behaviors of the client centered plans) will be 3/31/22. Pathways Grameet with [consulting professional/qualified 2/21/22 to ensure all weekly.  V112: Treatment plant client's current behave [consulting licensed professional] will be professional] will be professional will be profe	e updated no later than roup Home Director will licensed professional] effective corrections are being made as will be updated to reflect professional/qualified providing oversight and the that treatment plans are up up Home Director will meet sed professional/qualified to 2/21/22 to ensure all				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					R		
		MHL036-337	B. WING		02/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
		508 N RAN	SOM STREET				
SERENITY	/ HOUSE		, NC 28054				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u>,                                      </u>	PROVIDER'S PLAN OF CORRECTIO	N (YE	5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPI	LETE	
V 293	Continued From page	e 50	V 293				
	\/131/133: All staff ma	embers will have nurse aid					
		before their date of hire.					
	Criminal background						
	•	ained in the employee's file.					
	•	t will be completed and					
	_	files no later than 3/15/22.					
		ne Director will meet with					
	[consulting licensed p						
		e 2/21/22 to ensure all					
	corrections are being						
		mplete 10 hours in the group					
	home as required. Pa						
		onference for [QP#1] for					
		I concerns. Pathways Group					
		eet with [consulting licensed					
		professional] effective					
		corrections are being made					
	weekly.	un I Inmana voill namtiones to					
	_	up Homes will continue to					
		heduling that will allow two ned on each shift. In the					
		call out, there is a proper					
		at will be utilized to ensure					
		are met. Staffing needs will					
	•	3/15/22. Pathways Group					
		eet with [consulting licensed					
		professional] effective					
		corrections are being made					
	weekly.	•					
	V297: The LP will cor	mplete their hours in person					
	at the group home un	lless it is not possible due to					
		the event that there is a					
		will complete therapy via					
		phone call. [consulting					
	-	/qualified professional] will					
		t and consultation to ensure					
		uirements. Pathways Group					
		eet with [consulting licensed					
		professional] effective					
	2/21/22 to ensure all	corrections are being made					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL036-337	B. WING		R 02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE		SOM STREET			
			, NC 20054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 293	Continued From page	e 51	V 293			
V 250	weekly. V366/367: Incident rewithin 72 hours and incompleted for all incideacility. Staff are provereports to complete of occurs. Pathways Growith [consulting licens professional] effective corrections are being V736: Originally there room door. Once direct this was a violation, the removed. Pathways It of discuss getting the Group Home Director licensed professional effective 2/21/22 to elbeing made weekly. V293: Pathways Group Iconsulting licensed professional oversee all citations are correct be completed to doculicensed professional provides supervision. Pathways Director will met and have approping forward to ensudecrease in occurrent Director will meet with professional/qualified	eports will be completed incident reports will be dents that occur in the deed paper copies of incident in shift when an incident oup Home Director will meet sed professional/qualified e 2/21/22 to ensure all made weekly. It was a lock on the laundry octor was made aware that the lock was immediately Director will contact landlord house painted. Pathways it will meet with [consulting and all corrections are copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies and all copies and all copies and all copies are that these issues copies and all copies and all copies and all copies and all copies are that these issues copies and all copies are that these issues copies and all copies and all copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies and all copies are that these issues copies and all copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies and all copies and all copies are that these issues copies are that these issues copies and all copies are that the copies are that the copies are that the copies are that the copies are that t				
	signed on 2/15/22 by "What immediate acti ensure the safety of t	the third POP written and the L-QP#2 revealed: on will the facility take to he consumers in your care? o make sure the above				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R	
	MHL036-337	B. WING		02/17/2022	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE	508 N RAN	ISOM STREET			
SEKENITI 1100SE	GASTONIA	A, NC 28054			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 293 Continued From page	e 52	V 293			
happens. V107/108: Pathways ensure that job descr the files of all employ Homes by 2/25/22. A client exhibits behavio AWOLS, etc by 2/25/2 Director will meet with professional/qualified 2/21/22 to ensure all weekly. V109: QP will be resp director in getting stat behaviors. QP will ne in accordance with go behaviors of the clien no later than 2/25/22. Director will meet with professional/qualified 2/21/22 to ensure all weekly. V112: Treatment plan client's current behav [consulting licensed p professional] will be p consultation to ensure to par. Pathways Gro with [consulting licens professional] effective corrections are being V131/133: All staff me registries completed I Criminal background completed and mainta If items are missing, i placed in employees Pathways Group Hon [consulting licensed p	Group Homes Director will intions and education are in ees at Pathways Group II staff will be trained if a pors such as sexualized, 22. Pathways Group Home in [consulting licensed professional] effective corrections are being made consible for assisting the ffed trained for client ed to update treatment plans poals that line up with the it. All PCPS will be updated Pathways Group Home in [consulting licensed professional] effective corrections are being made in swill be updated to reflect iors no later than 2/25/22. For of essional/qualified providing oversight and in that treatment plans are up up Home Director will meet sed professional/qualified in a cylonical professional/qualified in a cylonical professional professional/qualified in the employee's file. It will be completed and files no later than 2/25/22. In the Director will meet with professional/qualified in 2/21/22 to ensure all	V 293			

Division of Health Service Regulation

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Division of Health Service Regulation

MHL036-337    B. WING		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
MALE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  508 N RANSOM STREET  GASTONIA, No. 28084  (A41) (EACH DEFICIENCY MUST BE PRECEDED BY FILL REQUIRED FOR THE CONTROL OF THE PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FILL REQUIRED FOR THE CONTROL OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  V 293 Continued From page 53  V 294: Our QP will complete 10 hours in the group home as required, Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/122 to ensure all corrections are being made weekly.  V 295: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/122 to ensure all corrections are being made weekly.  V 297: The LP will complete their hours in person at the group home unless it is not possible due to COVID exposure. In the event that there is a COVID exposure. In the event that there is a COVID exposure. In the event that there is a COVID exposure. In the event that there is a covid to ensure that LP meets all requirements. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group						R	
SERENTY HOUSE  SUMMARY STATEMENT OF DEFICIENCES ASTONIA, NO 28054    CALID   SUMMARY STATEMENT OF DEFICIENCES IN PARTY   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENC'S MUST BE PRECEDED BY PAUL TAG   PREPTX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPTX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE DATE			MHL036-337	B. WING		l .	
(A4) ID PROVIDERS PLAN OF CORRECTION (CACH DEPICIENCIES TAG)  WAS USUMMARY STATEMENT OF DEPICIENCIES PREETX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 293  Continued From page 53  V 294: Our QP will complete 10 hours in the group home as required. Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to adress all concerns. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/2/1/22 to ensure all corrections are being made weekly.  V 296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/22 to ensure all corrections are being made weekly.  V 297: The LP will complete their hours in person at the group home unless it is not possible due to COVID exposure, LP will complete therapy via telehealth and not via phone call. [consulting licensed professional/qualified professional] effective that LP meets all requirements. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
CASTONIA, NO. 28054   CACH DEPICIENCY MUST BE PRECEDED BY PULL   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   CACH CORRECTIVE ACTION SHOULD BE   CROSS-REFERENCED TO THE APPROPRIATE   DATE	CEDENITY	/ HOUSE	508 N RAI	NSOM STREET			
PREFIX TAG	SERENII	HOUSE	GASTONI	A, NC 28054			
V294: Our QP will complete 10 hours in the group home as required. Pathways Director has scheduled a phone conference for [CP#1] for 2/15/22 to address all concerns. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/122 to ensure all corrections are being made weekly.  V296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/22 to ensure all corrections are being made weekly.  V297: The LP will complete their hours in person at the group home unless it is not possible due to COVID exposure. In the event that there is a COVID exposure, LP will complete therapy via telehealth and not via phone call. [consulting licensed professional/qualified professional] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERT	D BE COMPLETE	
home as required. Pathways Director has scheduled a phone conference for [QP#1] for 2/15/22 to address all concerns. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/22 to ensure all corrections are being made weekly.  V296: Pathways Group Homes will continue to hire and complete scheduling that will allow two people to be maintained on each shift. In the event that there is a call out, there is a proper chain of command that will be utilized to ensure that coverage needs are met. Staffing needs will be met no later than 2/25/22. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective 2/21/22 to ensure all corrections are being made weekly.  V297: The LP will complete their hours in person at the group home unless it is not possible due to COVID exposure. In the event that there is a COVID exposure. In the event that there is a COVID exposure. In the open call. [consulting licensed professional/qualified professional] will be providing oversight and consultation to ensure that LP meets all requirements. Pathways Group Home Director will meet with [consulting licensed professional/qualified professional] effective	V 293	Continued From page	53	V 293			
weekly.  V366/367: Incident reports will be completed within 72 hours and incident reports will be completed for all incidents that occur in the facility. Staff are provided paper copies of incident reports to complete on shift when an incident occurs. Pathways Group Home Director will meet		home as required. Pa scheduled a phone of 2/15/22 to address all Home Director will me professional/qualified 2/21/22 to ensure all of weekly. V296: Pathways Groundrie and complete schepeople to be maintain event that there is a cochain of command that that coverage needs a be met no later than 2 Home Director will me professional/qualified 2/21/22 to ensure all of weekly. V297: The LP will con at the group home un COVID exposure. In the GOVID exposure, LP telehealth and not via licensed professional/ be providing oversigh that LP meets all required by the	thways Director has onference for [QP#1] for concerns. Pathways Group set with [consulting licensed professional] effective corrections are being made up Homes will continue to needuling that will allow two sed on each shift. In the all out, there is a proper at will be utilized to ensure are met. Staffing needs will 2/25/22. Pathways Group set with [consulting licensed professional] effective corrections are being made on the event that there is a will complete therapy via phone call. [consulting licensed professional] will the and consultation to ensure suirements. Pathways Group set with [consulting licensed professional] effective corrections are being made on the event that there is a will complete therapy via phone call. [consulting licensed professional] effective corrections are being made on the event with [consulting licensed professional] effective corrections are being made on the event that occur in the ded paper copies of incident on shift when an incident				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
			B WING		R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE	508 N RA	NSOM STREET		
JEKEMII	1 11003L	GASTON	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
V 293	Continued From page	e 54	V 293		
	room door. Once dire this was a violation, the removed. Pathways I to discuss getting the Group Home Director licensed professional, effective 2/21/22 to elbeing made weekly. V293: Pathways Group [consulting licensed professional] oversee all citations are correct be completed to doculicensed professional, provides supervision. Pathways Director will met and have approping forward to ensudecrease in occurren. Director will meet with professional/qualified.	e was a lock on the laundry actor was made aware that the lock was immediately Director will contact landlord house painted. Pathways will meet with [consulting /qualified professional] ansure all corrections are up Director will have professional/qualified experations to ensure that acted. A Consultation log will ament each time [consulting /qualified professional] With her assistance, and the sum of the consultation in t			
		d Former Client #4 ranged			
	in age from 13-16 year diagnosed with a vari	ars old. They were ety of mental health needs			
	_	ted to, Attention Deficit			
		r, Post-Traumatic Stress			
	Disorder, Conduct Dis				
		, Major Depressive Disorder, e Disorder, and Disruptive			
		Disorder, and Disruptive Disorder. Client #1 had a			
		ation, thoughts of harming			
	,	and verbal and physical			
	_	2 had a history of aggressive			
		nad a history of suicidal			
		ive outbursts. Former Client			

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						,
		MUI 026 227	B. WING		R	
		MHL036-337	B. WC		02/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		508 N RA	NSOM STREET			
SERENITY	/ HOUSE		IA, NC 28054			
			17, 110 20004			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
			1,,,,,			
V 293	Continued From page	e 55	V 293			
	#4 had a history of se	elf-harm and cutting, suicidal				
	ideation, thoughts of I	•				
		g away. Clients #1, #2, #3,				
		•				
		displayed incidents of				
		. Despite client histories,				
		ent strategies to address				
	sexualized behaviors	- ·				
		d not received training in				
		outh. There was no initial				
	strategies for Client #					
		nts completed for Clients #1,				
	#2, #3, and Former C	lient #4 after multiple				
	episodes of highly se	xualized behaviors. Incident				
	reports were not com	pleted making it impossible				
	to track incidents of a	ggression, assault, property				
	destruction, running a	away, or sexualized				
	behaviors. There was	s a lack of supervision for				
	Clients #1, #2, #3, an	d Former Client #4 due to				
		ft at times, as well as the				
		ied Professional #1 and				
	Licensed Professiona					
		ntained with signed job				
	descriptions and educ	<b>.</b>				
	•	ermore, some staff were not				
		background and Health				
		stry checks. The facility was				
		onal belongings on the floor,				
		ills and doors were chipped				
	•	alternative egress route was				
		le lock requiring a key for				
		ency constitutes a Type A1				
		ous neglect and must be				
		ays. An administrative				
		is imposed. If the violation is				
	not corrected within 2					
		y of \$500.00 per day will be				
	imposed for each day					
	compliance beyond the	ne 23rd day.				

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					1 _	
			D WING		F	
		MHL036-337	B. WING		02/1	7/2022
NAME OF DE	ROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR SOLT LIER					
SERENITY	HOUSE		ISOM STREET			
0		GASTONIA	A, NC 28054			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 204	O	- 50	V 294			
V 294	Continued From page	9 56	V 294			
V 294	27G .1702 Residentia	al Tx. Child/Adol -Req. for Q	V 294			
	P					
	1					
	10A NCAC 27G .1702	DECUIDEMENTS OF				
	QUALIFIED PROFES					
		utilize at least one direct				
	care staff who meets					
		as set forth in 10A NCAC				
	27G .0104(18). In ad	dition, this qualified				
	professional shall hav	ve two years of direct client				
	care experience.	•				
	(b) For each facility of	of five or less beds:				
		d professional specified in				
	. ,	Rule shall perform clinical				
	• ,	•				
		sponsibilities a minimum of				
	10 hours each week;					
	` '	time shall occur when				
	children or adolescen	ts are awake and present in				
	the facility.					
	(c) For each facility o	of six or more beds:				
		d professional specified in				
	` '	Rule shall perform clinical				
		sponsibilities a minimum of				
	32 hours each week;	- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				
	•	time shall occur when				
	` '					
		ts are awake and present in				
	the facility.					
		ody responsible for each				
		and implement written				
		ne clinical and administrative				
	responsibilities of its of	qualified professional(s). At				
	a minimum these poli	cies shall include:				
		of its associate				
	. ,	forth in Rule .1703 of this				
	Section;					
	·	emergencies;				
	` ,	•				
		direct psychoeducational				
	services to children of					
	(4) participation	n in treatment planning				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
					R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
SERENIT	Y HOUSE		ANSOM STREET		
	T	GASTON	IIA, NC 28054		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 294	Continued From page	e 57	V 294		
	meetings; (5) coordination adolescent's treatment	n of each child or			
	a minimum of ten hou of the time when ado present. The findings  Review on 2/8/22 of 0-Admitted 10/21/20; -Diagnosed with Con-	nd record review, the all #1 (QP#1) failed to administrative responsibilities are each week at least 70% descents were awake and are:  Client #1's record revealed:  duct Disorder, Obsessive			
	Compulsive Disorder Stressor Related Disorder -16 years old.	, Unspecified Trauma or order;			
	-Admitted 6/3/21; -Diagnosed with Post	Client #2's record revealed: -Traumatic Stress Disorder, order, Attention Deficit r;			
	-Admitted 1/18/22; -Diagnosed with Disri Disorder, Post-Traum	eractivity Disorder, Other			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			7 11 20123 11 101 _		R	e l	
		MHL036-337	B. WING		1	7/2022	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SERENITY	HOUSE		SOM STREET , NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 294	Continued From page -13 years old.  Review on 2/14/22 of -Hired 2/5/19; -Signed job description "provide and/or ass training for residentialdevelop task analysis implementation of goat training and staff deveperforming clinical aresponsibilities a minimand 75% shall occur wadolescents are awake management of the different facility, supervision or regarding responsibilities implementation of each treatment plan"  Interview on 2/8/22 w -QP#1 came to the facilients and stays apprenticed and stays apprenticed in the stay of the s	QP#1's record revealed: on dated 8/14/19 revealed: ure completion of required assistant employees ses and/or strategies for the alscomplete all required elopment activities and administrative mum of 40 hours a week when the children or se and present in the facility, ay to day operation of the paraprofessionals ties related to the ch child or adolescents  ith Client #1 revealed: cility every other week for  ith Client #2 revealed: cility weekly to check on the roximately one hour.  ith Client #3 revealed: saw her at the facility.	V 294		IATE	DATE	
	-QP#1 came to the fa	or LP in the facility. with Staff #2 revealed: cility every one to three 30-90 minutes in the facility.					

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Interview on 2/16/22 with Staff #3 revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:	Division of Health Service Negui
MHL036-337  B. WING	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SERENITY HOUSE  SOB N RANSOM STREET GASTONIA, NC 28054  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294  Continued From page 59  -QP#1 came to the facility twice monthly for	AND PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SERENITY HOUSE  SOB N RANSOM STREET GASTONIA, NC 28054  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294  Continued From page 59  -QP#1 came to the facility twice monthly for	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  508 N RANSOM STREET  GASTONIA, NC 28054   (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294 Continued From page 59  -QP#1 came to the facility twice monthly for	
SERENITY HOUSE  508 N RANSOM STREET GASTONIA, NC 28054  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294  Continued From page 59 -QP#1 came to the facility twice monthly for	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294 Continued From page 59  -QP#1 came to the facility twice monthly for	NAME OF PROVIDER OR SUPPLIER
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294 Continued From page 59  -QP#1 came to the facility twice monthly for	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294 Continued From page 59 -QP#1 came to the facility twice monthly for	SERENITY HOUSE
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 294  Continued From page 59  -QP#1 came to the facility twice monthly for	SUMMA DV ST
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  V 294  Continued From page 59  -QP#1 came to the facility twice monthly for	(//4) 10
V 294 Continued From page 59 -QP#1 came to the facility twice monthly for	
-QP#1 came to the facility twice monthly for	
-QP#1 came to the facility twice monthly for	
	V 294 Continued From page
	-QP#1 came to the fa
approximately one near.	
	approximately one ne
Interview on 2/16/22 with the QP#1 revealed:	Interview on 2/16/22 v
-Completed virtual visits to the facility;	
-Completed most of her work from the office;	
-Worked when the clients were in school and only	
saw the clients virtually;	
-Did not meet with the LP for clinical supervision.	
-Did not meet with the Limbi dimical supervision.	-Did flot ffleet with the
Interview on 2/15/22 with the Licensee-Qualified	Interview on 2/15/22 v
Professional #2 revealed:	
-Was aware the QP#1 needed to be present in	
the facility for 10 hours weekly with 70% of the	
time being when the clients were present and	
awake:	
-Was not aware the QP#1 was not present in the	,
facility when the clients were present;	
-Will ensure the QP#1 is present in the facility as	
required in the future.	required in the future.
This definion and a managed into 40.0	This deficiency is seen
This deficiency is cross referenced into 10A	
NCAC 27G .1701 Scope (V293) for a Type A1	
rule violation and must be corrected within 23	
days.	days.
V 296 27G .1704 Residential Tx. Child/Adol - Min. V 296	V 296 27G .1704 Residentia
Staffing	Staffing
10A NCAC 27G .1704 MINIMUM STAFFING	10A NCAC 27G .1704
REQUIREMENTS	
(a) A qualified professional shall be available by	
telephone or page. A direct care staff shall be	telephone or page. A
able to reach the facility within 30 minutes at all	able to reach the facil
times.	times.
(b) The minimum number of direct care staff	(b) The minimum nur
required when children or adolescents are	required when childre
present and awake is as follows:	_ ·
(1) two direct care staff shall be present for	'

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		MHL036-337	B. WING		02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	/ HOUSE	508 N RA	NSOM STREET		
GASTONIA		A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 296	Continued From page	e 60	V 296		
	(2) three direct for five, six, seven or adolescents; and (3) four direct on nine, ten, eleven or to adolescents. (c) The minimum number during child or adolescents follows: (1) two direct cand one shall be awarchildren or adolescent (2) two direct cand both shall be awarchildren or adolescent (3) three direct of which two shall be asleep for nine, ten, eadolescents. (d) In addition to the care staff set forth in Rule, more direct care the facility based on to individual needs as siplan. (e) Each facility shall supervision of childre are away from the facility or adolescent's needs as specified in	care staff shall be present for velve children or mber of direct care staff scent sleep hours is as are staff shall be present ke for one through four its; are staff shall be present ake for five through eight its; and care staff shall be present awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this e staff shall be required in the child or adolescent's pecified in the treatment  I be responsible for ensuring in or adolescents when they cility in accordance with the individual strengths and the treatment plan.			
	This Rule is not met Based on interview a	as evidenced by: nd record review, the facility			

Division of Health Service Regulation

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MHL038-337  MHC04-10-10-10-10-10-10-10-10-10-10-10-10-10-		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  508 N RANSOM STREET  GASTONIA, NC 28054  PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY SILL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 296  Continued From page 61  Review on 2/8/22 of Client #1's record revealed: -Admitted 10/21/20; -Diagnosed with Conduct Disorder, Obsessive Compulsive Disorder, Unspecified Trauma or Stressor Related Disorder; -16 years old.  Review on 2/8/22 of Client #2's record revealed: -Admitted 8/3/21; -Diagnosed with Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Distruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 with Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Distruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Other Reactions to Severe Stress; -13 years old.  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed: -Interviews on 2/8/22 with Clients #1, #2, and #3 revealed: -Interviews on 2/8/22 with Clients #1, #2, and #3 revealed: -Interviews on 2/8/22 with Clients #1, #2, and #3 revealed: -Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:				A. BUILDING		<sub>R</sub>	
SERENTY HOUSE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)  V 296  Continued From page 61 failed to ensure minimum staffing ratios of two staff for up to four adolescents. The findings are:  Review on 2/8/22 of Client #1's record revealed: -Admitted 10/21/20; -Diagnosed with Conduct Disorder, Obsessive Compulsive Disorder, Unspecified Trauma or Stressor Related Disorder; -16 years old.  Review on 2/8/22 of Client #2's record revealed: -Admitted 6/3/21; -Diagnosed with Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Disruptive Mood Dysregulation Disorder, Patentian Deficit Hyperactivity Disorder, Other Reactions to Severe Stress; -13 years old.  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed: -Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:			MHL036-337	B. WING			22
(24) ID PROVIDER'S PLAN OF CORRECTION (25) PROVIDER'S PLAN OF CORRECTION (25) (EACH CORRECTIVE ACTION SHOULD BE COMPETED TO THE APPROPRIATE DEFICIENCY)  V 296  Continued From page 61 failed to ensure minimum staffling ratios of two staff for up to four adolescents. The findings are:  Review on 2/8/22 of Client #1's record revealed: -Admitted 10/21/20; -Diagnosed with Conduct Disorder, Obsessive Compulsive Disorder, Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #2's record revealed: -Admitted 6/3/21; -Diagnosed with Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Other Reactions to Severe Stress; -13 years old.  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 296  Continued From page 61  failed to ensure minimum staffing ratios of two staff for up to four adolescents. The findings are:  Review on 2/8/22 of Client #1's record revealed: -Admitted 10/21/20; -Diagnosed with Conduct Disorder, Obsessive Compulsive Disorder, Unspecified Trauma or Stressor Related Disorder; -16 years old.  Review on 2/8/22 of Client #2's record revealed: -Admitted 6/3/21; -Diagnosed with Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Other Reactions to Severe Stress; -13 years old.  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:	SERENITY HOUSE						
failed to ensure minimum staffing ratios of two staff for up to four adolescents. The findings are:  Review on 2/8/22 of Client #1's record revealed: -Admitted 10/21/20; -Diagnosed with Conduct Disorder, Obsessive Compulsive Disorder, Unspecified Trauma or Stressor Related Disorder; -16 years old.  Review on 2/8/22 of Client #2's record revealed: -Admitted 6/3/21; -Diagnosed with Post-Traumatic Stress Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder; -14 years old.  Review on 2/8/22 of Client #3's record revealed: -Admitted 1/18/22; -Diagnosed with Disruptive Mood Dysregulation Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Other Reactions to Severe Stress; -13 years old.  Interviews on 2/8/22 with Clients #1, #2, and #3 revealed:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CON	MPLETE
sometimes there is only one staff working; -Only Staff #1 worked this morning when the clients awoke and had breakfast; -Only Staff #2 worked last night when the clients had dinner and prepared for bed.  Interview on 1/21/22 with Former Staff #7 revealed: -There was supposed to be two staff per shift but sometimes only one staff worked per shift due to staff calling out;	V 296	failed to ensure mining staff for up to four adding review on 2/8/22 of 0-Admitted 10/21/20; -Diagnosed with Concompulsive Disorder Stressor Related Disorder Disorder Disorder Disorder Disorder Disorder Disorder Disorder Stressor Stressor Related Disorder Post-Traum Attention Deficit Hype Reactions to Severe Stressor Disorder	num staffing ratios of two plescents. The findings are: Client #1's record revealed: duct Disorder, Obsessive, Unspecified Trauma or order; Client #2's record revealed: -Traumatic Stress Disorder, porder, Attention Deficit r; Client #3's record revealed: -Untive Mood Dysregulation patic Stress Disorder, Practivity Disorder, Other Stress; with Clients #1, #2, and #3 rked each shift, but haly one staff working; If this morning when the disorder bed. with Former Staff #7 If to be two staff per shift but	V 296	DEFICIENCY		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL036-337	B. WING		R 02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SERENITY HOUSE 508 N RAM			SOM STREET		
02.12.1111		GASTONIA	, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 296	Continued From page	: 62	V 296		
	(L-QP#2) would only	schedule one staff per shift.			
	revealed: -Two staff usually wor	with Staff #1, #2, and #3 ked per shift; staff worked per shift due to			
	-Tried to schedule two sometimes had difficu staff calling out resulti -Will continue to sche	with the L-QP#2 revealed: b staff to work each shift but allty with staffing ratios due to ang in only one staff at times; adule two staff per shift and ate staff coverage should at.			
	NCAC 27G .1701 Sco	es referenced into 10A ope (V293) for a Type A1 of be corrected within 23			
V 297	27G .1705 Residentia P	ıl Tx. Child/Adol - Req. for L	V 297		
	provided in each facili week by a licensed pro this Rule, licensed pro individual who holds a license issued by the a human service profe Carolina. For substar shall include a license Specialist or a certifie (b) The consultation this Rule shall include	SIONALS cal consultation shall be ity at least four hours a rofessional. For purposes of ofessional means an a license or provisional governing board regulating ession in the State of North nce-related disorders this ad Clinical Addiction d Clinical Supervisor. specified in Paragraph (a) of			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
SERENIT	/ HOUSE		ANSOM STREET IIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 297	services; or (3) involvement specific treatment platissues.  This Rule is not met	I in Rule .1702 of this roup or family therapy t in child or adolescent ns or overall program as evidenced by:	V 297		
	to face clinical consul each week. The findi Review on 2/8/22 of 0 -Admitted 10/21/20; -Diagnosed with Cond	I (LP) failed to provide face tation at least four hours ngs are: Client #1's record revealed: duct Disorder, Obsessive Unspecified Trauma or			
	-Admitted 6/3/21; -Diagnosed with Post Major Depressive Dis Hyperactivity Disorde -14 years old.  Review on 2/8/22 of 0 -Admitted 1/18/22; -Diagnosed with Disru Disorder, Post-Traum	Client #3's record revealed: uptive Mood Dysregulation atic Stress Disorder,			
	Reactions to Severe 3 -13 years old.	eractivity Disorder, Other Stress; the LP's record revealed:			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL036-337	B. WING		R <b>02/17/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SERENITY	/ HOUSE	508 N RAN	SOM STREET			
GASTONIA		GASTONIA	, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 297	Continued From page	e 64	V 297			
V 297	-Hired 9/30/20; -Signed job descriptionface to face clinical provided in each facilmust provide clinical Qualified Professional treatment team on the the clientsinvolvem adolescents specific the programming"  Review on 2/10/22 of 11/1/2021-2/7/2022 re-Notes reflecting sessional #3 ranging from all the result of the LP talked to her on the LP talked to her on the facetime; -Length of time she sidepending on what shouse but thinks it will be the computer or telephonic clients present limiting-Length of time she sidepending or time she sidepending to the computer or telephonic clients present limiting-Length of time she sidepending time she	on dated 7/8/21 revealed: " consultation shall be ity at least 4 hours a week al supervision to the il monthlyupdate e progress of therapy with tent in the children or treatment plans and overall  If the LP's notes for evealed: sions with Clients #1, #2, 15-30 minutes in duration.  If Client #1 revealed: the facility; the telephone or via  poke with the LP varied the wanted to discuss but 10 minutes weekly; telast time she was at the tas before Christmas; the Client #2 revealed: the facility; to yon Mondays using a te in the living room with all the g confidentiality; to poke with the LP varied but	V 297			
	it was usually about 1 -Cannot remember th the facility, but it was	e last time the LP was at				
	-LP did not come to the -LP talked to her on the	ith Client #3 revealed: ne facility; he telephone or via staff's 's tablet was used then the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R		
		MHL036-337	B. WING		1	7/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
SERENITY HOUSE 508 N RAN		NSOM STREET					
021(21(1))			IA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 297	Continued From page	e 65	V 297				
V 201	telephone was also us have sound); -Sat in the living room the other clients heard they were also in the rooms; -Length of time she spit was generally only was clarified to mean minutes.  Interview on 1/21/22 or revealed: -The LP would call the with the clients on the -Never saw the LP in Interview on 2/16/22 or -LP conducted therapicalls.  Interview on 2/16/22 or -LP conducted therapicalls or computer time -LP was not at the fact 2021.  Interview on 2/16/22 or -LP conducted therapicalls or computer time; -LP was not at the fact 2021.  Interview on 2/16/22 or -LP conducted therapicomputer time; -LP was not at the fact 2021.  Interview on 2/16/22 or -LP conducted therapicomputer time; -LP was not at the fact 2021.  Clients had weekly or -Clients went outside privacy when they spending.	and spoke with the LP but d what was discussed as living room or in adjoining poke with the LP varied but a couple of minutes" which approximately 5-10  with Former Staff #7  a facility weekly to speak telephone; the facility.  with Staff #1 revealed: y sessions via telephone  with Staff #2 revealed: y sessions via telephone be; bility since before December,  with Staff #3 revealed: y via telephone calls and bility for several weeks but last date the LP was lideo calls with the LP; on the front porch to ensure oke with the LP on the					
	Interview on 2/16/22 v	with the Qualified					

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Professional #1 (QP#1) revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
					R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY	HOUSE		NSOM STREET IA, NC 28054		
0/0.15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	l over
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 297	Continued From page	e 66	V 297		
	to the pandemic but of telehealth appointment appointment. Did not meet with the Attempted interviews unsuccessful. A required Health Service Regul 11:45am for the Licent #2 (L-QP#2) to arrange between DHSR and the arrange a telephone is was received from the was made by DHSR of telephone call to the I was on the LP's telephone.	with the LP were lest was made by Division of lation (DHSR) on 2/14/22 at lisee-Qualified Professional lige a telephone interview lihe LP. Despite attempts to linerview, no telephone call lie LP. An additional attempt line linerview in 2/16/22 at 9:50am via linerup. The following message linerup in the vireless ling is not available. Please			
	-Was not aware the L facility to conduct the -Was not acceptable the facility; -Will ensure the LP is meet with each client sessions in the future  This deficiency is cross NCAC 27G .1701 Scott	the LP was not present at in the facility weekly to for confidential therapy			
V 366	27G .0603 Incident R	esponse Requirments	V 366		
	10A NCAC 27G .0603 RESPONSE REQUIF CATEGORY A AND E (a) Category A and B	REMENTS FOR			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  508 N RANSOM STREET  GASTONIA, NC 28054  V 366  Continued From page 67  Implement written policies governing their response to level I, I or II il incidents. The policies shall require the provider to respond by:  (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10 A NCAC 28B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICFMR providers shall address incidents as required by the federal regulations in 42 CFR Part 43 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICFMR providers, shall develop and implement written policies governing their response to a level III in cidents and B providers, excluding ICFMR providers and B providers, excluding ICFMR providers is and III		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  508 N RANSOM STREET GASTONIA, NC 20054  (X41)D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366 Continued From page 67 implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing corrective measures according to the 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 (7) maintaining documentation regarding Subparagraphs (a)(f) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, and III addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, and III 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	7410 1 2741	or correction.	is Ervin is an incident in the misera.	A. BUILDING: _		JOHN EETEB	
SERENTY HOUSE  SERENTY HOUSE  SUMMARY STATEMENT OF DEFICIENCES  (C4) ID PREFEX TAG  (C4) ID PREFEX TAG  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MAST BE PRECEDED BY FULL TAG  (C4) ID PREFEX TAG  (C5) ID PREFEX TAG  (C7) IM REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366  Continued From page 67  Implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing orrective measures according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10 A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule, (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICFMR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICFMR providers, shall develop and implement written policies governing						R	
SUMMARY STATEMENT OF DEFICIENCES   CASTONIA, NC 20054			MHL036-337	B. WING		02/17/2022	
(A) ID PROVIDENS PLAN OF CORRECTION (A) DEPRICIENCIES IN PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IN PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366 Continued From page 67 Implement written policies governing their response to level I, II or II II incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (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. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers, shall develop and implement written policies governing	NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366  Continued From page 67  V 366  Continued From page 67  V 366  Implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:  (1) attending to the health and safety needs of individuals involved in the incident;  (2) determining the cause of the incident;  (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;  (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;  (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;  (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  (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule, (b) In addition to the requirements set forth in Paragraph (a) of this Rule, (CF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (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	OFDENIT	/ HOUSE	508 N RA	NSOM STREET			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V 366  Continued From page 67 implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule, (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. (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	SERENII	HOUSE	GASTON	IA, NC 28054			
implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:  (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (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 83 Subpart I. (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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	E
response to level I, II or III incidents. The policies shall require the provider to respond by:  (1) attending to the health and safety needs of individuals involved in the incident;  (2) determining the cause of the incident;  (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;  (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;  (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;  (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  (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.  (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.  (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	V 366	Continued From page	e 67	V 366			
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 by:  (1) immediately securing the client record by:  (A) obtaining the client record;		implement written pol response to level I, II shall require the providence of individuals involved (2) determining (3) developing measures according to timeframes not to except timeframes not to except timeframes not to except timeframes not to except timeframes (4) developing to prevent similar incispecified timeframes (5) assigning properties of timeframes (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFF (c) In addition to the Paragraph (a) of this providers, excluding I develop and implement their response to a let while the provider is corrupted to the policies shall required by:  (1) immediately by:	icies governing their or III incidents. The policies ider to respond by: the health and safety needs d in the incident; the cause of the incident; and implementing corrective to provider specified seed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and confidentiality requirements article 2A, 10A NCAC 26B, 3 and 45 CFR Parts 160 and documentation regarding through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ts as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B CF/MR providers, shall ent written policies governing wel III incident that occurs delivering a billable service on the provider's premises. uire the provider to respond				

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DIVISION	n Health Service Negu	ialion	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					-	,
		MUI 026 227	B. WING		R <b>02/17/2022</b>	
		MHL036-337	1		J 02/1	112022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		508 N RAN	ISOM STREET			
SERENITY	HOUSE		A, NC 28054			
	OUR MAR DV OT		1	DD0//DEDIG DI AN OF CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF		DATE
				DEFICIENCY)		
V/ 266	Continued Frame none	- 00	V 366			
V 366	Continued From page	9 08	V 300			
	(D) transferring	the copy to an internal				
	review team;					
	(2) convening a	a meeting of an internal				
		hours of the incident. The				
	internal review team s	shall consist of individuals				
	who were not involve	d in the incident and who				
	were not responsible	for the client's direct care or				
	-	al oversight of the client's				
	•	f the incident. The internal				
	review team shall con	nplete all of the activities as				
	follows:	'				
		opy of the client record to				
	• •	nd causes of the incident				
		dations for minimizing the				
	occurrence of future i					
		r information needed;				
		n preliminary findings of fact				
	, ,	ys of the incident. The				
		f fact shall be sent to the				
		nent area the provider is				
		IE where the client resides,				
	if different; and	Where the elicitivesides,				
		written report signed by the				
	` '	onths of the incident. The				
		ent to the LME in whose				
	•	rovider is located and to the				
		resides, if different. The				
	final written report sha					
	identified by the interr					
		uments pertinent to the				
	· · · · · · · · · · · · · · · · · · ·	ake recommendations for				
		ence of future incidents. If				
	_					
		d for the report are not				
		months of the incident, the				
		ovider an extension of up to				
		nit the final report; and				
		notifying the following:				
		ponsible for the catchment				
	area where the service	ces are provided pursuant to	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SERENITY HOUSE			NSOM STREET		
	T		A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
V 366	Continued From page	e 69	V 366		
	different; (C) the provider for maintaining and up treatment plan, if different provider; (D) the Departm (E) the client's applicable; and	erent from the reporting			
	failed to implement the reporting. The finding Review on 2/15/22 of reporting policy reveause. "Reporting of any incommedication error: a taken to remedy the pasfety, well-being and who are directly involved in the standardized in report shall be completed include all pertinent fapersons involved, with damages and method shall be placed in the	and record review, the facility eir policy on incident gs are:  the undated incident aled: cident, unusual occurrence, after appropriate action is problem and to ensure the dicare of those individuals are died. The report should be incident reporting form. The eted in detain and shall acts such as time, place, messes, extent of injury or dis of remedy. The copy incident file at the facility"			
	report shall be comple on the standardized in report shall be comple include all pertinent fa persons involved, with damages and method shall be placed in the	eted. The report should be neident reporting form. The eted in detain and shall acts such as time, place, nesses, extent of injury or distributions.			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		MHL036-337	B. WING		1	7/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
SERENITY	/ HOUSE		ANSOM STREET			
	CUMMARY CT		IIA, NC 28054	DROVIDERIO DI ANI OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page	e 70	V 366			
		duct Disorder, Obsessive r, Unspecified Trauma or order;				
	-Admitted 6/3/21; -Diagnosed with Post Major Depressive Dis Hyperactivity Disorde	Client #2's record revealed: t-Traumatic Stress Disorder, sorder, Attention Deficit er;				
	-Admitted 1/18/22; -Diagnosed with Disri Disorder, Post-Traum	eractivity Disorder, Other				
	record revealed: -Admitted 9/29/21; -Discharged 1/26/21; -14 years old; -Diagnosed with Post Attention Deficit Hype	t-traumatic Stress Disorder,				
	unsigned handwritter -First set of letters (to of a sexual nature inc interactions between 2/10/22; -Second set of letters one-sided) of a sexual	otaling 13 pages one-sided) cluding requests for sexual the writers was reviewed on				

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reviewed on 2/15/22.

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B WING		R
		MHL036-337	B. WING		02/17/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	NOVIDEN ON OUT LIEN			12, 211 0002	
SERENITY	/ HOUSE		NSOM STREET		
0		GASTON	IA, NC 28054		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
V 366	Continued From page	. 71	V 366		
V 300	Continued From page	<del>5</del>	000		
	Review on 2/8/22 of u	ındated and unsigned letter			
	written by staff reveal				
		ayed vulgar language and			
	threats toward others				
		ayed incidents of physical			
	•				
	aggression and assault; -Staff #3: FC#4 displayed continuous incidents of "violent, destructive, and manipulative behaviors consistently" and threatened and assaulted peers				
	_	aterieu and assaulteu peers			
	and staff;				
	-Staff #6: FC#4 displayed vulgar language,				
	threatening staff, and	"physical rampage."			
		email correspondence dated			
		e-Qualified Professional #2			
	' '	eatment team members			
	revealed:				
	-30-day notice to disc				
	"physically aggressive	e with other clients as well			
	as our staff. She had	destroyed property,			
	threatened to kill clier	nts, attempted to go AWOL"			
	and threatened to ma	ke false allegations in order			
	to have staff fired.	-			
	Review on 2/8/22 of t	he facility's incident reports			
	for period 11/1/21 - 2/				
	-No incident reports of				
		for Clients #1, #2, #3, and			
	FC#4;	, <b>_</b> , , <b>_</b> , ,			
		ts completed on FC#4			
	(11/21/21, 1/13/22, ar	•			
	aggressive and assau				
	aggressive and assat	and to bolications.			
	Interview on 2/8/22 w	ith Client #1 revealed:			
		s of a sexual nature to			
	•	s of a sexual fialule to			
	Client #3.				
		:11 01: 1 110			
	Interview on 2/8/22 w	ith Client #2 revealed:			

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-Denied writing letters of a sexual nature to Client

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	MHL036-337	B. WING		02	R / <b>17/2022</b>
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		ANSOM STREET	,		
SERENITY HOUSE	GASTO	NIA, NC 28054			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
revealed: -The first set of letters wa	Client #3 revealed: f a sexual nature to her; the letters but was we a sexual relationship  2/9/22 with FC#4 was verview with FC#4's she advised FC#4 was er discharge from the rant permission for her ed in fear it would upset  1 Licensee-Qualified and House Manager pisodes of property  1 2/15/22 with the L-QP#2 as written between ere discovered during the 2; s was written between ant reports on the she did not think it was a cited two times on	V 366			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					R	
		MHL036-337	B. WING		02/17/2022	
			-		1 02/11/2022	_
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SERENITY	/ HOUSE		NSOM STREET			
		GASTONI	A, NC 28054			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	≣
V 366	Continued From page	e 73	V 366			
		st be corrected within 23				
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	level II incidents, except the provision of billab consumer is on the princidents and level II to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the besubmitted on a for Secretary. The report in person, facsimile of means. The report of information:  (1) reporting pridentification information:  (2) client identification information:  (3) type of incidentification information:  (4) description (5) status of the cause of the incident;  (6) other individent or responding.  (b) Category A and Best missing or incomplete shall submit an updat report recipients by the day whenever:	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within ricident to the LME retchment area where within 72 hours of the incident. The report shall m provided by the t may be submitted via mail, r encrypted electronic reall include the following  rovider contact and tion; fication information; flent; of incident; the effort to determine the and duals or authorities notified  B providers shall explain any the information. The provider the end of the next business				
	report recipients by the day whenever:	he end of the next business  Thas reason to believe that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
			5		R	
		MHL036-337	B. WING		02/17/	/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENIT	Y HOUSE	508 N RA	NSOM STREET			
OLINLINII	1 110002	GASTONI	A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	e 74	V 367			
	erroneous, misleading (2) the provider required on the incide unavailable. (c) Category A and B upon request by the L obtained regarding the (1) hospital recinformation; (2) reports by construction (3) the provider (4) Category A and B of all level III incident Mental Health, Develor Substance Abuse Selbecoming aware of the providers shall send a incidents involving a construction of the catchment area where the catch	g or otherwise unreliable; or robtains information ent form that was previously a providers shall submit, LME, other information e incident, including: ords including confidential other authorities; and it's response to the incident. It's providers shall send a copy reports to the Division of opmental Disabilities and rvices within 72 hours of the incident. Category A a copy of all level III client death to the Division of ation within 72 hours of the incident. In cases of the incident. In cases of the incident in cases of the days of use of seclusion der shall report the death are by 10A NCAC 26C to 27E .0104(e)(18). It is providers shall send a set LME responsible for the eservices are provided. It is provided to a form provided electronic means and shall remation as follows: errors that do not meet the or level III incident; it is a client or his living area; client property or property in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL036-337	B. WING		02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SERENITY	HOUSE		SOM STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 367	been no reportable in incidents have occurr meet any of the criter (a) and (d) of this Rul through (4) of this Pa  This Rule is not met Based on interview at failed to notify the loc Level II incidents with aware of the incidents  Review on 2/8/22 of C-Admitted 6/3/21; -Diagnosed with Post Major Depressive Dis Hyperactivity Disorder 14 years old.  Review on 2/8/22 of Frecord revealed: -Admitted 9/29/21; -Discharged 1/26/21; -14 years old;	as evidenced by: as evidenced by: as evidenced by: and record review, the facility al management entity of all in 72 hours of becoming by: The findings are: Client #2's record revealed:  -Traumatic Stress Disorder, order, Attention Deficit r;  Former Client #4's (FC#4)  -traumatic Stress Disorder, eractivity Disorder,	V 367	DEFICIENCY)		
	Review on 2/8/22 of t for period 11/1/21 - 2/ -Report dated 11/21/2					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-337	B. WING			R 17/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	1 021	1172022
			NSOM STREET			
SERENITY	HOUSE	GASTON	IA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 367	Continued From page	<del>2</del> 76	V 367			
	unwanted sexual beh Client #2.	avior made by FC#4 against				
	Interview on 2/8/22 w -Did not want to discu sexualized behavior w					
	Attempted interview on 2/9/22 with FC#4 was unsuccessful. During interview with FC#4's Mother-Legal Guardian, she advised FC#4 was finally stable at home after discharge from the facility. She would not grant permission for her daughter to be interviewed in fear it would upset her progress.					
	Interview on 2/15/22 with the Licensee-Qualified Professional #2 revealed: -It was an oversight that a Level II incident report was not completed regarding the 11/21/21 allegation of unwanted sexual behavior made by FC#4 against Client #2, but an internal investigation was completed; -Will ensure all Level II incident reports are completed through the North Carolina Incident Response Improvement System in the future.					
		tutes a re-cited deficiency. een cited three times on 6/10/21.				
	NCAC 27G .1701 Sco	ess referenced into 10A ope (V293) for a Type A1 st be corrected within 23				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 EXTERIOR REQUIRI					

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STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R		
		MHL036-337	B. WING		02/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SERENITY	SERENITY HOUSE 508 N RANSOM STREET						
OLIKLINII	1110001	GASTON	A, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE		
V 736	Continued From page	e 77	V 736				
	(c) Each facility and it maintained in a safe,						
	- 12:05pm revealed: -Large rug measuring covered by debris and -Two plastic mats ead 3'x5' on the driveway -One pink blanket on -Metal rake face up of -Kitchen cabinet over the wall leaning on the -Bottom right drawer significant build-up of substance; -Rear exit door in kitch lock which required a being inaccessible to -Many personal items disarray in clients' be -Missing blind on the bedroom; -Single closet door had approximately 3"x3" of back bedroom;	the driveway; In the front lawn; If the stove separating from If the e exhaust fan; If the refrigerator had If spilled juice or other If then was locked with a cable If the resulting in the door If anyone without a key; If the stacked on the floor in drooms; I left window in Client #1's If the stove separating on the bottom left side in the					
	-Single closet door ha approximately 3"x3" o back bedroom; -Double closet door w						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		MHL036-337	B. WING		02/17/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
SERENITY HOUSE			NSOM STREET			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	IA, NC 28054	PROVIDER'S PLAN OF CORRECTION	V (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 736	Continued From page	<del>2</del> 78	V 736			
	-Facility walls and docand dirty.	ors were chipped, scuffed,				
	Licensee-Qualified Pr Division of Health Ser 2/7/22 at 4:58pm reve -Would have staff rem	email correspondence from rofessional #2 (L-QP#2) to rvice Regulation staff dated ealed: nove the cable lock from the y to ensure the door was				
	Interview on 2/9/22 with Client #1 revealed: -Pulled down the blind from the window during a behavioral episode when she was angry.					
	Interviews on 2/7/22 with L-QP#2 and House Manager revealed: -Was not aware the doorways needed to be unobstructed; -Would remove the cable lock if required; -The damages to the closet areas in the back bedroom were the result of Former Client #4's behavioral outbursts.					
	Interview on 2/15/22 with L-QP#2 revealed: -Removed the cable lock from the rear door; -Will arrange to have the facility cleaned and painted.					
	•	een cited four times on 9/21, and 6/10/21.				
	7/29/19, 10/3/19, 2/19/21, and 6/10/21.  This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.					

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