STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED		
			7. BOILESTIC.			R	
MHL026-890			B. WING			7/2022	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SERENIT	TY THERAPEUTIC SE	RVICES #2		D HILL ROA			
	I			LS, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDEL SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
	An annual and follo on March 17, 2022.						
	This facility is licens category: 10A NCA Living for Adults wit	C 27G .5600C St	upervised				
	This facility is licensed for 6 beds and currently has a census of 5. the survey sample consisted of audits of 3 current clients.						
V 367	27G .0604 Incident Reporting Requirements		V 367				
	identification inform (2) client ider (3) type of inc (4) descriptio	UIREMENTS FO B PROVIDERS B providers shall accept deaths, that able services or we providers premiser rendered any service incident to the LI catchment area we deaths incident. The form provided by ort may be submeror encrypted elements and include the provider contact action; of tification informatical action in the provider contact action;	R I report all coccur during while the ses or level III g the clients service within ME where s of e report shall the itted via mail, ctronic following and tion;				
<u></u>	cause of the incide						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL026-890		B. WING		03/1	₹ 7/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADD 1446 SAN			DRESS, CITY, S ID HILL ROA LLS, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 367	or responding. (b) Category A and missing or incomple shall submit an upor report recipients by day whenever: (1) the provide erroneous, mislead (2) the provide erroneous, mislead (2) the provide required on the inciunavailable. (c) Category A and upon request by the obtained regarding (1) hospital reinformation; (2) reports by (3) the provide (d) Category A and of all level III incide Mental Health, Dev Substance Abuse Secoming aware of providers shall send incidents involving a Health Service Reg becoming aware of client death within sor restraint, the provimmediately, as reconstructed to the category A and report quarterly to the category A and report quarterly to the category and report shall be by the Secretary via include summary incl	B providers shall explain any ete information. The provider lated report to all required the end of the next business der has reason to believe that d in the report may be ing or otherwise unreliable; or ler obtains information dent form that was previously. B providers shall submit, et LME, other information the incident, including: ecords including confidential of other authorities; and ler's response to the incident. B providers shall send a copy not reports to the Division of elopmental Disabilities and dervices within 72 hours of the incident. Category A did a copy of all level III a client death to the Division of ulation within 72 hours of the incident. In cases of the incident. In cases of the incident. In cases of the incident in the death pured by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided. Submitted on a form provided a electronic means and shall formation as follows: In errors that do not meet the	V 367			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL026-890		B. WING _			R 17/2022
SERENITY THERAPEUTIC SERVICES #2 1446 SAN			REET ADDRESS, CIT 46 SAND HILL RO DPE MILLS, NC 2	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 367	definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit	Il or level III incident; interventions that do no evel II or level III incident; of a client or his living ar of client property or proper of client; number of level II and levered; and ent indicating that there h incidents whenever no arred during the quarter to eria as set forth in Paragule and Subparagraphs	rea; erty in rel III nave that graphs			
	failed to ensure crit submitted to the Lo within 72 hours as a Review on 03/17/22 Response Improve revealed no level II aggressive behavior involvement and an Review on 03/15/22 revealed: - 29 year old male. - Admission date of Diagnoses of Mild	view and interview the faical incident reports were cal Management Entity (required. The findings and 2 of the North Carolina Informent System (IRIS) web incident reports for clien or resulting in law enforce in injury to staff #1 on 12/2 of client #2's record	e (LME) e. ncident site t #2's ement 28/21.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
	MHL026-890			B. WING			R 03/17/2022	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SERENI	TY THERAPEUTIC SE	RVICES #2		ID HILL ROA LLS, NC 283				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 367	Continued From particles of the factor of th	nd Hypothyroidic of a "DHHS (D Services) Restrictives) Restrictive into 2/28/21. S:50am 1 minute. In grestrictive into 3 minutes [Staff lient #2] and exiving shift exchange shift exchange shift exchange shift exchange shift exchange with second 12/28/2 prepend before aff #1] was have a standing in the control of the day, when standing in the control of the day, when standing in the control of the day, when standing in the control of the day w	Department of rictive ent #2 revealed: ervention (be if #1] walked plain to him ange but before t #2] began to say f**k you what to do. Client #2] that a in [Client #2] thing her on the skin causing ued to swing at the event ing an shift of [Client #2] to in heard the #2] time to cool was in the office taff as well as [Staff #1] doorway. [Staff from the door change. [Client alked off out the 2] a few					

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STATE FORM 6899 7ARU11 If continuation sheet 4 of 6

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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		MHL026-890	B. WING			7/2022
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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	OLIMANA DV. OTA		-			41.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG			TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V/ 267	Continued From no	4	V 367			
V 367	Continued From pa	ige 4	V 307			
	#1] walked outside	to talk with [Client #2]. and				
		she was only giving a shift				
		re [Staff #1] could finish talking				
		sing profanity towards [Staff				
		b***h. you think you all can tell				
		aff #1] attempted to explain to				
		ift exchange was for staff but				
		rged at [Staff #1] swung				
		ight side of the face breaking				
		er face to bleed [Client #2]				
		at [Staff #1]. [Staff #1] then				
		swing and placed [Client #2]				
		ap while in the wrap [Client #2]				
		und and laid there stating that				
		f #1] informed [Client #2] that				
		y. [Staff #1] checked [Client				
		nd bruises being that Client				
		ground but there were none.				
		ne QP (Qualified Professional)				
		ound decision to send [Client				
		[Client #2] was transported to				
		ceive psychiatric treatment."				
	Interview on 03/17/	22 client #2 stated:				
	 - He was 29 years old. - He did not recall the incident on 12/28/21. - He had no issues or concerns at the facility. Interview on 03/16/22 staff #1 stated: - She had worked at the facility since 2019. - She recalled the incident on 12/28/21 with client #2. - Client #2 had become aggressive and hit her. - She got a cut and client #2 was not injured. She placed client #2 in a therapeutic wrap and he dropped to the ground. She contacted the QP and she called the ambulance. 					
	A crisis officer and ambulance arrived.She had completed reports regarding the					
	incident.					

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #2 1446 SAND HILL ROAD HOPE MILLS, NC 28348 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FULL TAG V 367 Continued From page 5 Interview on 03/17/22 the QP stated: - Incident reports had been completed for the 12/28/21 incident between client #2 and staff #1 She had not completed an IRIS report for the 12/28/21 incident She understood any aggressive act by a client which results in law enforcement involvement or injury to others should be reported to the LME within 72 hours via IRIS.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1446 SAND HILL ROAD HOPE MILLS, NC 28348 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 5 Interview on 03/17/22 the QP stated: - Incident reports had been completed for the 12/28/21 incident She had not completed an IRIS report for the 12/28/21 incident She understood any aggressive act by a client which results in law enforcement involvement or injury to others should be reported to the LME		MUI 026 900		B WING				
SERENITY THERAPEUTIC SERVICES #2 1446 SAND HILL ROAD HOPE MILLS, NC 28348 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 5 V 367 Interview on 03/17/22 the QP stated: - Incident reports had been completed for the 12/28/21 incident between client #2 and staff #1 She had not completed an IRIS report for the 12/28/21 incident She understood any aggressive act by a client which results in law enforcement involvement or injury to others should be reported to the LME			MHL026-890	b. WING		03/1	7/2022	
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		- Incident reports had 12/28/21 incident be - She had not compute 12/28/21 incident She understood a which results in law injury to others should be shou	ad been completed for the etween client #2 and staff #1. pleted an IRIS report for the my aggressive act by a client renforcement involvement or all be reported to the LME					

Division of Health Service Regulation STATE FORM