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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED							
ANDILAN	or contribution	IDENTIFICATION NOWIBER.	A. BUILDING: _									
		MHL047-172	B. WING		R-C 07/28/2022							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
SERENITY THERAPEUTIC SERVICES #12 6928 LAURINBURG ROAD RAEFORD, NC 28376												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETE DATE								
V 000	INITIAL COMMENTS		V 000									
	on July 28, 2022. Th	w-up survey was completed e complaint (intake unsubstantiated. Deficiency										
	category: 10A NCAC	d for the following service 27G. 5600C Adults with Developmental										
	has a census of 6.	d for 6 beds and currently onsisted of audits of 3										
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131									
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.										
	failed to access the F Registry (HCPR) prio three audited staff (Lo	as evidenced by: ew and interview the facility lealth Care Personnel or to employment for one of ead Staff). The findings are: of the Lead Staff's personnel										

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

(X6) DATE TITLE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D. WING		l l	₹-C	
		MHL047-172	B. WING		07	/28/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE, ZIP CODE			
SERENIT	Y THERAPEUTIC SERVI	CES #12	AURINBURG ROAI DRD, NC 28376	0			
(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	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 131	record revealed: -Hired date: 8/25/21HCPR check was ac -There was no evider employment. Interview on 7/28/22 Professional revealed -The human resource responsible for acces employees prior to el	excessed 5/2022. Ince of the HCPR prior to with the Qualified d: e department was ssing HCPR for all mployment. ead Staff HCPR was not	V 131				

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