Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-337	A. BUILDING: ______ B. WING ______	R 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HOUSE	508 N RANSOM STREET GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on August 5, 2022. The complaint was unsubstantiated (Intake #NC00190428). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 4 current clients and 1 former client.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have	V 109		

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met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.
(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.
(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.

This Rule is not met as evidenced by:
Based on interview, record review, and observation, 1 of 3 audited Qualified Professionals (Qualified Professional #1/Licensee (QP#1/L)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:

Review on 8/1/22 of the QP#1/L's record revealed:
-Hired 2/5/19.

Review on 7/25/22 and 7/26/22 of Client #1's record revealed:
-Admitted 1/18/22;
-Diagnosed with Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Other Reaction to Severe Stress;
-13 years old;
-History of suicidal thoughts, verbal and physical aggression, and anger outbursts.

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Interviews on 7/25/22 and 8/1/22 with Client #1 revealed:
-Recalled taking Forner Client #5 (FC#5) to meet FC#5's mother when "she (FC#5) was going home to live;"
-Staff #3 drove FC#5 to meet FC#5's mother because "something happened to her (FC#5's mother's) car;"
-She was also in the facility vehicle along with Staff #3 and Clients #2 and #4 when FC#5 was taken to meet FC#5's mother;
-FC#5's mother's vehicle was on the side of the highway "where the concrete was in between the lanes;"
-Staff #4 stopped the facility vehicle on the highway near FC#5's mother's vehicle;
-Staff #4 and FC#5 got out of the facility vehicle and walked along the highway to FC#5's mother's vehicle;
-Staff #3 waited with her and Clients #2 and #4 when Staff #4 and FC#5 walked away;
-Staff #4 left FC#5 with FC#5's mother;
-Staff #4 returned to the facility vehicle and drove away.

Review on 7/25/22 and 7/26/22 of Client #2's record revealed:
-Admitted 1/31/22;
-Diagnosed with Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder, Mild Intellectual Developmental Disability;
-14 years old;
-History of absent without leave (AWOL).

Interviews on 7/25/22 and 8/1/22 with Client #2 revealed:
-Recalled taking FC#5 to meet FC#5's mother;
-"Don't know what happened to her (FC#5) but

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she left and [Client #3] came to take her spot;"
-FC#5's mother's vehicle was on the side of the highway and law enforcement was present;
-FC#5's mother's vehicle "was on the grassy side of the highway and not in the middle;"
-Was in the facility vehicle with Staff #3 and #4, and Clients #1, #4, and FC#5;
-Staff #4 "stopped on the highway and got out" and walked FC#5 to FC#5's mother;
-Staff #4 got back in the facility vehicle and drove away leaving FC#5 with FC#5's mother.

Review on 8/1/22 and 8/3/22 of Client #4's record revealed:
-Admitted 6/6/22;
-Diagnosed with Post-Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder;
-15 years old;
-History of suicidal and homicidal ideation, verbal and physical aggression, assault resulting in criminal charges, and AWOL.

Interview on 8/1/22 with Client #4 revealed:
-Was in the facility vehicle with Staff #3 and #4, and Clients #1, #2, and FC#5 taking FC#5 to meet FC#5's mother "to be sent home;"
-Stopped on the highway "by the grassy side of the highway directly behind [FC#5's] mother's vehicle ;"
-"[FC#5] and staff (Staff #4) got out of the (facility) vehicle and went to [FC#5's] mom's vehicle with all of [FC#5's] stuff (clothing and personal belongings);"
-Returned to the facility after dropping off FC#5.

Review on 7/27/22 of FC#5's record revealed:
-Admitted 6/3/22;
-Discharged 6/27/22;
-Diagnosed with Major Depressive Disorder, Oppositional Defiant Disorder, Unspecified

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V 109	Continued From page 4 Anxiety Disorder, Borderline Intellectual Functioning, Autism Spectrum Disorder; -16 years old; -History of suicidal ideation and attempts, verbal and physical aggression, assault resulting in criminal charges, and AWOL. Interview on 7/25/22 with FC#5 revealed: -Was picked up from the respite program by facility staff (QP#1/L and House Manager (HM)); -Two staff (Staff #3 and Staff #4) and all of the clients (Clients #1, #2, and #4) "drove on the interstate (highway) and they were on the road and took me to the stone column that separates the lanes and unpacked me to my mom." Interview on 7/21/22 with FC#5's Legal Guardian/Mother revealed: -FC#5 was discharged on 6/27/22 from the facility due to safety concerns; -FC#5 was admitted on 6/27/22 to a respite program for two days; -Facility staff assisted with transportation by picking up FC#5 from the respite program and driving her to the facility's administrative office on 6/29/22; -Was on her way to pick up FC#5 from the facility's administrative office and was involved in an accident on the highway; -Staff #4 drove to the site of the accident and dropped off FC#5 "on the interstate with her belongings;" -Was on the "left side of the interstate pulled over on the shoulder dealing with the details of the accident." Interview on 8/1/22 with FC#5's Care Coordinator (CC) revealed: -FC#5 was discharged from the facility due to safety concerns;	V 109		

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-FC#5 was admitted to a local respite program for two days;
-Facility staff picked up FC#5 from the respite program;
-FC#5's mother borrowed a vehicle to drive to the facility to pick up FC#5;
-FC#5's mother was involved in an accident on her way to the facility;
-Facility staff met FC#5's mother and dropped off FC#5 to FC#5's mother on the highway but could not provide further details regarding the drop off location or circumstances.

Interview on 8/1/22 with Staff #3 revealed:
-FC#5 was released from a local respite program;
-FC#5's mother was involved in an accident on the highway on her way to the facility to pick up FC#5;
-QP#1/L instructed her and Staff #4 to take Clients #1, #2, #4, and FC#5 to meet FC#5's mother and drop off FC#5;
-Met FC#5's mother at the accident scene "on the highway near exit 29" to drop off FC#5;
-Staff #4 parked on the right-hand side of the highway which was "the grassy side;"
-Waited in the facility vehicle with Clients #1, #2, and #4 while Staff #4 walked FC#5 to FC#5's mother.

Interview on 8/1/22 with Staff #4 revealed:
-Took FC#5 to meet FC#5's mother at the end of June, 2022;
-Was informed by the QP#1/L that FC#5 had "to return to her mom;"
-FC#5's mother had trouble with her vehicle and had been "rear-ended" in an accident on the highway;
-Met FC#5's mother on the highway close to exit 29;
-Pulled onto the shoulder "by the concrete divider

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...on the left-hand side of the highway;"
-Told Clients #1, #2, and #4 "not to get out of their seats" and to remain in the vehicle with Staff #3;
-Only "allowed [FC#5] to get out of her seat and walked to her mom's car."

Interviews on 7/25/22, 8/1/22, and 8/3/22 with QP#1/L revealed:
-FC#5 was taken to a local hospital on 6/17/22 after aggressive and destructive behavior resulting in property destruction and assault of staff and a law enforcement officer;
-Conducted an emergency Child and Family Team (CFT) meeting on 6/22/22 to discuss immediate emergency discharge due to the facility not being able to meet FC#5's needs and posing a serious risk to the health and safety of the facility staff and clients;
-Picked up FC#5 from the local hospital on 6/24/22 because FC#5's CC informed QP#1/L that an emergency discharge could not be completed, and it was the facility's responsibility to find placement for FC#5;
-Admitted FC#5 to a respite program in a neighboring county on 6/27/22;
-FC#5's respite program discharged FC#5 on 6/29/22 threatening to report FC#5's mother to the local Department of Social Services if FC#5's mother did not pick up FC#5;
-Assisted FC#5's mother with transportation by going with the House Manager and picked up FC#5 from the respite program and brought FC#5 to the facility's administrative office to await FC#5's mother's arrival;
-FC#5's mother had borrowed a vehicle to pick up FC#5 and was involved in an accident with the vehicle on the highway on the way to pick up FC#5;
-"Was only trying to help" by picking up FC#5 from the respite program;

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-Was unable to identify how she could ensure the health and safety of the facility staff and clients when they were in the presence of FC#5 after a decision had previously been made that FC#5's needs were too great for the facility;
-Transporting FC#5 posed a danger and only did so "to help [FC#5's] mother;"
-Realized "staff and clients were in danger" when they "stopped on the highway" to drop FC#5 to FC#5's mother;
-"Would no longer transport clients who were not current clients" in the facility.

Observation on 8/1/22 at approximately 4:30pm of the interstate highway where FC#5 was dropped off to her mother revealed:
-Eight lane highway with a concrete divider separating four lanes headed southbound and four lanes headed northbound. The left-hand side of the southbound lanes were lined with the concrete barrier and the right-hand side of the southbound lanes were lined with grass and trees. The posted speed limit was 60 miles per hour.

Review on 8/4/22 of the Plan of Protection signed by QP#1/L dated 8/4/22 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Pathways Group Homes (Licensee) will consult with [Consultant] and attorneys to ensure the correct decision will be made if there is any uncertainty with how to move forward with a discharge.
-Pathways Group Homes has undergone training on 08/02/22 with [Consultant] in regards to discharge planning and the distinct differences between DHSR (Division of Health Service Regulation) and MCO (Managed Care Organization) rules to ensure compliance with

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both.
-Pathways Group Homes will not transport a client who has been discharged from the facility.
-Pathways Group Homes will continue to put the needs of the client first while maintaining compliance with our policies and procedures and NC Statutes.

Describe your plans to make sure the above happens.
-Pathways Group Homes will continue to undergo training monthly in any areas of need via [Consultant] monthly to ensure full competence with N.C (North Carolina) DHSR Statues.
-Pathways Group Homes will follow all requirements of DHSR and ensure to follow their policies and procedures.
-Pathways Group Homes will consult with [Consultant] and attorneys for questions on how to handle a situation that causes uncertainty.
-Pathways Group Homes will not place other clients at risk by transporting a client that has been discharged from their facility. Going forward, Pathways Group Homes will remain diligent in following what the statutes require."

This deficiency constitutes a recited deficiency.

Clients #1, #2, #4, and Former Client #5 (FC#5) are 13-16 years old. Their mental health needs include Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and Intellectual Developmental Disabilities. FC#5 was discharged from the facility due to the acuity of her needs and posing a health and safety threat to staff and clients. Two days after discharge from the facility and admission into a respite program, the Qualified Professional #1/Licensee

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(QP#1/L) and facility House Manager (HM) picked up FC#5 from the respite program and transported her to the facility's administrative offices awaiting pick-up by FC#5's mother. FC#5's mother was delayed on the highway as a result of vehicle trouble and accident. QP#1/L instructed Staff #3 and #4 to take Clients #1, #2, #4, and FC#5 and drop FC#5 to FC#5's mother on the highway. Staff #4 stopped and parked the facility vehicle on the shoulder of the highway in a four-lane flow of traffic where the speed limit was 60 miles per hour. Staff #4 and FC#5 walked along the highway to FC#5's mother while Clients #1, #2, and #4 remained in the parked vehicle with Staff #3. The decision and resulting action was detrimental to the health, safety, and welfare of the staff, clients, and FC#5. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.

V 367 — 27G .0604 Incident Reporting Requirements — V 367

10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall

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be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of

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Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to notify the local management entity of all Level II incidents within 72 hours of becoming aware of the incidents. The findings are:

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Review on 7/21/22 of the audio and written call reports provided by the County's Emergency Services Coordinator for period 4/1/22-7/20/22 revealed:
-Call to law enforcement on 5/5/22 at 7:20pm regarding a 13 year old female (Client #1) getting upset and breaking a window at the facility.

Review on 7/21/22 of North Carolina Incident Response Improvement System (NC IRIS) revealed:
-No incident report completed regarding the call to law enforcement on 5/5/22.

Interview on 8/1/22 with the Qualified Professional #1/Licensee revealed:
-Did not realize the 5/5/22 call to law enforcement regarding Client #1 breaking a window had not been reported through NC IRIS;
-Had re-trained staff regarding the use of NC IRIS;
-Will discuss with, and seek supervision from, her newly hired Consultant regarding incident reporting requirements in the future;
-Will continue to follow up with staff to ensure all incidents are reported and properly entered in NC IRIS.

This deficiency constitutes a recited deficiency and must be corrected within 30 days.

V 736 — 27G .0303(c) Facility and Grounds Maintenance — V 736

10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS
(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-337	A. BUILDING: ______ B. WING ______	R 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY HOUSE	508 N RANSOM STREET GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 13 odor. This Rule is not met as evidenced by: Based on interview and observation, the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are: Observation on 7/25/22 at approximately 6:30am - 7:30am revealed: -Two drawer filing cabinet in the side yard; -Bag of garbage on the steps at the side door; -No window coverings on Client #2's bedroom windows; -Two broken drawers on the right-hand side of Client #3's dresser. Interview on 7/25/22 with Client #2 revealed: -Pulled the blinds off her window when she "got mad;" -Unable to identify the date she pulled her blinds off her window. Interview on 7/25/22 with Client #3 revealed: -The two dresser drawers were "always broken;" -Denied action or knowledge of the damage to the dresser drawers. Interview on 8/1/22 with the Qualified Professional #1/Licensee revealed: -Client #2 pulled her blinds off her window several days ago; -Instructed staff to purchase new blinds for Client #2' bedroom windows; -Was aware Client #3's dresser drawers were broken as a result of use; -Staff put the filing cabinet in the yard when it	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 14 broke; -Instructed staff to put all garbage and broken items at the end of the driveway near to road for garbage pickup. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 736		