

## Appendix 1-B: Plan of Correction Form

Plan of Correction			
<p>Please complete <u>all</u> requested information and email completed Plan of Correction form to:</p> <p style="margin-left: 100px;">Plans.OfCorrection@dhlis.nc.gov</p>			
<b>Provider Name:</b>	Serenity Therapeutic Services, Inc	<b>Phone:</b>	910-904-7147
<b>Provider Contact Person for follow-up:</b>	Darrin McNeill/ Administrator	<b>Fax:</b>	910-904-7148
		<b>Email:</b>	dmcneill14@nc.rr.com
<b>Address:</b>	6928 Laurinburg Rd., Raeford, NC 28376		<b>Provider #:</b> MHL-047-172
Finding	Corrective Action Steps	Responsible Party	Timeline
<p>G.S. 131E-256 Health Care Personnel Registry                      1. The facility failed to access the Health Care Personnel Registry (HCPR) prior to employment for one of three audited staff (Lead Staff).</p>	<p>1. The HCPR was accessed in May 2022 for the Lead Staff, which was after an offer of employment. The Human Resources Manager will access the HCPR once an application is received for all prospective candidates. Once generated, the HR Manager will place the results of the HCPR check with the application packet, as well as maintain a spreadsheet containing the date the results were generated. If an offer of employment is given, the HR Manager will ensure the results of the HCPR check are filed in the employee's personnel file. The HR Manager will also provide a weekly update to the QP on all current applicants to ensure the deficiency does not reoccur.</p>	<p>Darrin McNeill</p>	<p><b>Implementation Date:</b> July 28, 2022</p> <p><b>Projected Completion Date:</b> August 12, 2022</p>

207 South Stewart Street  
Roxford, NC 26370  
Office #: (910) 904-7147  
Fax #: (910) 904-7148



**RECEIVED**

By cvhicks at 4:00 pm, Aug 17, 2022

**FAX**

To: NC DHHS

From: Da'nah Steele, ap

Attention: Division of Health Service Regulation

Fax #: 919-715-8078

Date: 8/13/2022

Re: POC for MHL-047-172

Pages: 6 pages including cover sheet

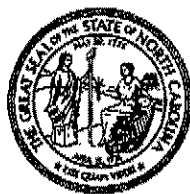
- Urgent
- For review
- Please comment
- Please reply
- Please recycle

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Comments:

Please see the attached POC for MHL-047-172.

Thank you,  
Da'nah Steele, ap



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor  
KODY H. KINSLEY • Secretary  
MARK PAYNE • Director, Division of Health Service Regulation

August 4, 2022

Ms. Da'nah Steele, Qualified Professional  
Serenity Therapeutic Services, Inc.  
207 S. Stewart Street  
Raeford, NC 28376

Re: Complaint and Follow-up Survey Completed July 28, 2022  
Serenity Therapeutic Services #12, 6928 Laurinberg Road, Raeford, NC 28376  
MHL# 047-172  
E-mail Address: [gpa@serenitytservices.com](mailto:gpa@serenitytservices.com)  
Intake #NC00191029

Dear Ms. Steele:

Thank you for the cooperation and courtesy extended during the complaint and follow-up survey completed July 28, 2022. The complaint was unsubstantiated.

As a result of the follow-up survey, it was determined that the deficiency is now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

Enclosed you will find the deficiency cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- The other tag cited is a standard level deficiency.

**Time Frames for Compliance**

- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is September 26, 2022.

**What to Include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mall Service Center, Raleigh, NC 27699-2718  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-718-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

August 4, 2022  
Ms. Da'nah Steele, QP

- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow-up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at 919-855-3822.

Sincerely,



Frances E. Hicks, MSW  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: [DHSR@Alliancebhc.org](mailto:DHSR@Alliancebhc.org)  
[DHSR\\_Letters@sandhillscenter.org](mailto:DHSR_Letters@sandhillscenter.org)  
Pam Pridgen, Administrative Supervisor

PRINTED: 07/29/2022  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/28/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SERENITY THERAPEUTIC SERVICES #12</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6928 LAURINBURG ROAD RAEFORD, NC 28376</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow-up survey was completed on July 28, 2022. The complaint (intake #NC00191029) was unsubstantiated. Deficiency cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities</p> <p>The facility is licensed for 6 beds and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 131	<p><b>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</b></p> <p><b>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY</b> (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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to access the Health Care Personnel Registry (HCPR) prior to employment for one of three audited staff (Lead Staff). The findings are:  Review on 7/28/22 of the Lead Staff's personnel</p>	V 131		

Division of Health Service Regulation

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

*Da'nah C. Clark*

TITLE **Qualified Professional**

(X6) DATE **8/13/22**

PRINTED: 07/29/2022  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/28/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SERENITY THERAPEUTIC SERVICES #12</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6926 LAURINBURG ROAD RAEFORD, NC 28376</b>
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(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 131	<p>Continued From page 1</p> <p>record revealed: -Hired date: 8/25/21. -HCPR check was accessed 5/2022. -There was no evidence of the HCPR prior to employment.</p> <p>Interview on 7/28/22 with the Qualified Professional revealed: -The human resource department was responsible for accessing HCPR for all employees prior to employment. -She confirmed the Lead Staff HCPR was not accessed prior to employment.</p>	V 131		