

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SERENITY THERAPEUTIC SERVICES #4	STREET ADDRESS, CITY, STATE, ZIP CODE 332 SOUTH MAIN STREET 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on August 21, 2023. The complaint (intake #NC00205155 and (ntake #NC00205172) were substantiated. No deficiencies were 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 5 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------