PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on August 30, 2023. The complaints were substantiated (intake #NC00205666, NC00205715, NC00206178 and NC00206180). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 2 current client and 1 former client.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 1 (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews one of three audited former staff (FS #5) and one of two audited current staff (#1) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 8/24/23 of the facility's personnel records revealed: Staff #1 -Date of hire was 7/25/23. -Hired as a Paraprofessional. FS #5 -Date of hire was 6/13/23. -Hired as a Paraprofessional. -Terminated 8/23 (no specific date). FS #3 -Date of hire was 5/17/23. -Hired as a Paraprofessional. -Terminated on 8/8/23. Review on 8/23/23 of client #1's record revealed: -Admission date of 4/25/23. -Diagnosis of Autism, Attention Deficit Hyperactivity Disorder, Neurobehavioral problems	V 110		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 2 of outbursts and obsessive behaviors. Review on 8/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Report dated 8/8/23-"On 8/8/2023 at approximately 8:30 am shortly before a staff meeting, [Staff #1] reported to [the Home Manager] an incident involving an allegation of abuse towards [client #1] that occurred on Saturday, 7/29/2023. [Staff #1] reported that [client #1] wanted a snack and attempted to go into the pantry; however, [FS #3] stopped him. As a result, [client #1] became upset and started to show signs of agitation by pacing and continuing to try to access the pantry. At this time, [Staff #1] stated that [FS #3] took [client #1] outside on the back porch to calm down; however, [client #1] remained agitated and upset, and sat in his swing. At this time, [Staff #1] reported that [FS #3] flicked a lit cigarette at [client #1] while he was in his swing, which caused a cigarette burn in his gym shorts [client #1] was not burned and proceeded to throw [client #1] back in his swing when he attempted to get up. Shortly after, [client #1] got up and went back inside the facility, but was still visibly upset. [Staff #1] said that [FS #3] then smacked [client #1] on the left side of his face, causing redness to his ear. [Staff #1] intervened and escorted [client #1] back outside to remove him from the area and stayed with [client #1] for the remainder of the shift." Attempts to interview client #1 on 8/23/23 revealed: -He could not be interviewed due to cognitive functioning. -He was nonverbal. Interview on 8/25/23 with FS #3 revealed: -He was aware of the allegation of abuse against	V 110		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 3 him related to client #1. -"I didn't put his hands on client #1 and I didn't throw a cigarette at him." -They had a house meeting and management called him into the office. -Management told him that they had a statement written on him regarding the incident with client #1. -He expressed to management that he wanted to see the statement that staff had written. -Management would not let him see the statement. -The staff who wrote the statement on him doesn't even know what happened because she worked on 1st shift. -He started to write a statement about the incident but stopped because management weren't listening to him telling his side of the story. -He stopped writing the statement and left out the facility. Interview on 8/25/23 with staff #1 revealed: -She witnessed the incident on 7/29/23 with FS #3 and client #1. -Client #1 had a behavior due to wanting a snack. -They were outside initially, and FS #3 brought client #1 back into the facility. -FS #3 then slapped client #1 on the side of face. -Client #1's ear was red after being slapped by FS #3. -Client #1 and FS #3 went back outside onto the patio area and client #1 continued having behaviors. -Client #1 kept getting in and out of the swing while they were on the patio. -FS #3 then pushed client #1 against the pole of the swing. -Client #1 sat back down on the swing and he started to calm down.	V 110		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 4 -"I guess [FS #3] was still mad with [client #1]. [FS #3] was smoking a cigarette and flicked the cigarette at [client #1] while it was still lit." -The lit cigarette fell onto client #1's lap while he was sitting on the swing. -The lit cigarette burned a small hole in the shorts client #1 was wearing. -The lit cigarette also burned the seat part of swing near client #1. -Client #1 was not burned by the lit cigarette. -She took client #1 away from FS #3 and put him in chair next to her while they were outside on the patio. -When client #1 sat down beside her, he was "constantly" shaking. -Client #1 "seemed to be frightened." -FS #5 also witnessed the incident with client #1 and FS #3. -She told the Lead Staff about the incident on 8/1/23. -The Lead Staff said she would talk to the Home Manager. -She thought the Home Manager talked to her about the late reporting on 8/4/23. -The Home Manager asked her why she didn't report the incident when it happened on 7/29/23. -She told the Home Manger she did not have her cell phone number. -She also told the Home Manager she reported the incident to the Lead Staff on 8/1/23. Interview on 8/24/23 with FS #5 revealed: -She witnessed the incident on 7/29/23 with FS #3 and client #1. -FS #3 and client #1 were in the patio area. -She saw FS #3 push client #1 up against the brick wall on the patio. -She told FS #3 that he should not be pushing client #1 up against the wall. -FS #3 told her "I used to work at a locked facility	V 110		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 5	V 110		

and this was how we dealt with clients."
-She did not see anymore of the incident because she went back inside the facility.
-Staff #1 also witnessed the incident between client #1 and FS #3.
-She reported the incident to the Home Manager on 7/31/23.
-The Home Manager said she would take care of the situation.
-"I'm not sure why I did not report the incident on 7/29/23 when it happened initially."

Interview on 8/25/23 with the Lead Staff revealed:
-She was not aware of the 7/29/23 incident with client #1 and FS #3 until 8/8/23 when they had the staff meeting.
-Staff #1 never reported the 7/29/23 incident with client #1 and FS #3 to her prior to 8/8/23.
-FS #5 never reported anything to her related to the 7/29/23 incident with client #1 and FS #3.

Interview on 8/24/23 with the Home Manager revealed:
-She was aware of 7/29/23 incident with client #1 and FS #3.
-She was told they were out back in the patio area when the incident occurred.
-She was told client #1 kept touching FS #3 and FS #3 did not want to be touched.
-She was told FS #3 flicked some cigarette ashes on client #1.
-Client #1's shorts had a small burn and there was a small burn on the swing.
-Client #1 was not burned by the cigarette ashes.
-She reported the incident to the Lead Qualified Professional and she came over to the facility on 8/8/23.
-They tried to talk to FS #3 about the incident with client #1.
-They asked FS #3 to write a statement about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 6	V 110		

incident and he refused.
-FS #3 told them he quit and he walked out of the facility on 8/8/23.
-She was told FS #5 also witnessed the incident with client #1 and FS #3 on 7/29/23.
-FS #5 did not report what she witnessed during that incident with client #1 and FS #3.
-They never talked to FS #5 about the incident because she quit at the beginning of August 2023.
-The incident was not reported to them until 8/8/23 by staff #1.
-Staff #1 did not report that incident to her prior to 8/8/23.
-Staff #1 said the reason she did not report the incident was because "she was afraid and did not want to start any trouble."

Interview on 8/24/23 with the Lead Qualified Professional revealed:
-She was aware of the incident on 7/29/23 with client #1 and FS #3.
-Staff #1 witnessed the incident with client #1 and FS #3.
-She was told FS #3 and client #1 were on the back porch area of the facility.
-She was told client #1 was upset prior to going outside about a snack.
-She was told FS #3 took client #1 outside so he could calm down.
-She was told FS #3 flicked the ashes of cigarette while it was still lit.
-She was told some of the ashes fell onto client #1's shorts.
-Client #1 was not burned from the lit cigarette, however his shorts were burned.
-She was also told FS #3 slammed client #1 into the swing.
-She was told client #1 was trying to get out of swing and FS #3 slammed him back into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 7 swing. -She was told during that incident FS #3 slapped client #1 in his face while they were on the inside of the facility. -Staff #1 said client #1's ear was a "little" red. -Staff #1 said she grabbed client #1 and kept him with her the remainder of the shift. -FS #5 was also present during that incident and possibly witnessed the incident. -Staff #1 reported the incident to them on 8/8/23. -Staff #1 did not give them an explanation as to why she reported the 7/29/23 incident late.	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 8 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are: Review on 8/23/23 of a personnel record for former staff (FS #4) revealed: -Date of hire was 5/17/23. -He was hired as a Paraprofessional. -He was terminated on 8/1/23. Review on 8/23/23 of former client (FC #5's) record revealed: -Admission date of 6/27/23. -Diagnoses of Autism with accompanying	V 132		

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6918 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 9 language impairment, Profound Intellectual Disability and PICA. -Discharge date of 8/12/23. Interviews on 8/23/23 and 8/24/23 with the local DSS Social Worker revealed: -On 8/3/23 the local County Sheriff's Department filed a complaint with her about FS #4 assaulting FC #5. -The local County's Sheriff's Department received a 911 call from an anonymous former staff who used to work at the facility. -The former staff alleged FS #4 assaulted FC #5 at the facility. -She went out to the facility on 8/3/23 to initiate the DSS investigation. -She did inform the facility of the allegations of abuse against FS #4. -She made the Home Manager aware of the allegations on 8/3/23 when she visited the facility. -The allegations were from an incident on 7/12/23 that happened with FS #4 and FC #5. Review on 8/24/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against FS #4 related to him assaulting FC #5. Interview on 8/24/23 with the Lead Qualified Professional revealed: -She was aware of DSS allegation of abuse against FS #4 that involved FC #5. -The Home Manager made her aware of the allegation of abuse on 8/3/23. -The incident supposedly happened on 7/12/23 with FS #4 and FC #5. -FC #5 went to the hospital due to a bruise he received on 7/7/23 during an incident with client #1.	V 132		

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 10 -The Home Manager told the DSS Social Worker there was a separate incident with client #1 and FC #5. -The DSS Social Worker was informed by the Home Manager client #1 bit FC #5 and they collided on 7/7/23 and that was why FC #5 went to the hospital on 7/12/23. -The allegation of abuse was not reported to HCPR because FS #4 was already terminated when the abuse allegation came to her attention on 8/3/23. -She confirmed the agency failed to report the allegations of abuse to HCPR within five working days.	V 132		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 11 progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure coordination was maintained between the facility operator and other qualified professionals who are responsible for treatment/habilitation or case management affecting one of one former client (FC #5). The findings are: Review on 8/23/23 of FC #5's record revealed: -Admission date of 6/27/23. -Diagnoses of Autism with accompanying language impairment, Profound Intellectual Disability and PICA. -Discharge date of 8/12/23. Reviews on 8/23/23 and 8/29/23 of in-house incident reports for FC #5 revealed: -7/7/23- "On 7/7/23 one of [FC #5's] housemate was having a behavior and was running and collided into [FC #5], in turn bit [FC #5] on his left shoulder ..." -7/12/23- "On 7/12/23, staff noticed bruising on the left side of [FC #5's] face near his eye. [FC #5] had an incident with another client prior to a few days before, with [FC #5] being colliding into the housemate, and being bitten, but the dark bruising on his eye was not observed at this time.	V 291		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 12 The decision was made to take [FC #5] to [Name of local hospital] for further assessment. A Computerized Tomography (CT) scan was completed but not noted no fractures or broken bones ..." Interview on 8/23/23 with FC #5's mother revealed: -She was the guardian for FC #5. -She removed FC #5 from the facility on 8/12/23. -"[FC #5] has very limited communication skills and can't defend himself." -She got a call from a Social Worker with the local Department of Social Services (DSS) on 8/4/23. -The Social Worker said there was an allegation of abuse involving FC #5. -The Social Worker said she was at the facility on 8/3/23 for an unannounced visit. -No one from the facility called her about the DSS investigation. -She called later and talked with the Home Manager about the allegation of abuse. -The Home Manager told her that accused staff was no longer working at the facility. -On 7/12/23 she called to check on FC #5 and was informed by the Home Manager that she was at the emergency room with FC #5. -The Home Manager said they needed to get a CT scan on FC #5. -The Home Manager said FC #5 and another client ran into each other and bumped heads on 7/7/23 when he was running to his bedroom. -She was told FC #5 had a black eye and his eye was also swollen. -"Once again, I was not called on 7/12/23 about [FC #5] going to the hospital." -The Home Manager said when FC #5 went to the hospital they were told FC #5 had a contusion.	V 291		

PRINTED: 09/05/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 13 -On 7/8/23 she called and spoke with the Home Manager. -The Home Manager informed her FC #5 was bitten on the shoulder on 7/7/23. -The Home Manager said FC #5 was bitten by one of the other clients. -She was not made aware of any of these incidents. -When she called to check on FC #5 that was when the Home Manager told her about those incidents. Interviews on 8/23/23 and 8/24/23 with the local DSS Social Worker revealed: -On 8/3/23 the local County Sheriff's Department filed a complaint with her about FS #4 assaulting FC #5. -The local County's Sheriff's Department received a 911 call from an anonymous former staff who used to work at the facility. -The former staff alleged FS #4 assaulted FC #5 at the facility. -She went out to the facility on 8/3/23 to initiate the DSS investigation. -She went to the facility again on 8/11/23. -She did inform the facility of the allegations of abuse against FS #4. -She made the Home Manager aware of the allegations on 8/3/23 when she visited the facility. -The allegations were from an incident on 7/12/23 that happened with FS #4 and FC #5. Interview on 8/24/23 with FC #5's Care Manager revealed: -On 7/7/23 FC #5 was bitten by another client at the facility. -She knew about the incident because FC #5's mother contacted her. -No one from the facility ever contacted her or FC #5's mother about FC #5 being bitten.	V 291		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 14 -FC #5 went to the hospital on 7/12/23 due to a bruise on his face. -FC #5's mother also called her about that incident. -The facility staff never contacted her about the hospital visit. -FC #5's mother said the only reason she knew was because she called the Home Manager to check on FC #5. -A DSS Social Worker visited the facility on 8/3/23 due to an allegation of abuse. -It was alleged that a facility staff abused FC #5. -The facility never made her or FC #5's mother aware of the abuse allegation against staff. -The DSS Social Worker called FC #5's mother and that was how she knew about the incident. -FC #5's mother called her and that was how she became aware of the incident. -"Once again", the facility never called about the abuse allegation. -She should have been contacted about the bite on 7/7/23, the hospital visit on 7/12/23 and the DSS investigation on 8/3/23. -FC #5's mother informed her of all three of those incidents and not any of the facility management. -The facility has 24 hours to report an incident to the Local Management Entity/Managed Care Organization (LME/MCO). -She talked with the Lead Qualified Professional and the Director/Licensee on 7/14/23 during a team meeting about making sure they report incidents to her and FC #5's mother related to FC #5. Interview on 8/24/23 with the Home Manager revealed: -The Lead Qualified Professional was responsible for contacting parents/guardians if there were incidents with the clients. -She thought the Lead Qualified Professional	V 291		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 15 contacted FC #5's mother about the bite incident, DSS investigation and hospital visit for FC #5. Interview on 8/24/23 with the Lead Qualified Professional revealed: -She was aware of DSS allegation of abuse against FS #4 that involved FC #5. -The Home Manager made her aware of the allegation of abuse on 8/3/23. -She wasn't sure if FC #5's mother was contacted by anyone from the agency about the DSS investigation. -FC #5's mother was notified when FC #5 went to the hospital. -She thought the guardian called the Home Manager and was told FC #5 was at the hospital. -FC #5's mother was also updated on the outcome of that hospital visit. -FC #5's mother was notified on 7/7/23 about FC #5 being bitten by client #1. -The Home Manager told FC #5's mother about the incident when FC #5 was bitten on 7/7/23. -FC #5's mother normally called the Home Manager daily to check on FC #5. -"We want to know what we are talking about and have the answers prior to calling a guardian or anyone else about an incident with a client." -Herself, the Home Manager or the Director/Licensee will contact guardians about incidents. -Depending on the severity of the incident will sometimes determine which one of them contacts the guardian. -They generally don't keep a log of reporting incidents when reporting to guardians. Interview on 8/24/23 with the Director/Licensee revealed: -As far as he knew FC #5's mother was informed of the hospital visit and when FC #5 was bitten by	V 291		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 16 client #1. -The LME/MCO was also aware of these incidents with FC #5 either verbally or by email. -They prefer to gather information and then call the guardians and Care Managers to give accurate information. -He tried to encourage management to send emails to guardians and other collateral contacts in order to have a record of the contact. -They also made phone calls to notify guardians of any incidents. -They normally don't record they made contact with that guardian. -Sometimes he made phone calls to guardians and other collateral contacts while he was driving. -He normally did not document that contact was made with those individuals.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	V 366		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 17 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;	V 366		

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 18 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level III incidents as required. The findings are: Review on 8/23/23 of a personnel record for former staff (FS #4) revealed: -Date of hire was 5/17/23. -He was hired as a Paraprofessional. -He was terminated on 8/1/23. Review on 8/23/23 of former client (FC #5's) record revealed: -Admission date of 6/27/23. -Diagnoses of Autism with accompanying language impairment, Profound Intellectual Disability and PICA. -Discharge date of 8/12/23. Interviews on 8/23/23 and 8/24/23 with the local DSS Social Worker revealed: -On 8/3/23 the local County Sheriff's Department filed a complaint with her about FS #4 assaulting FC #5. -The local County's Sheriff's Department received a 911 call from an anonymous former staff who used to work at the facility. -The former staff alleged FS #4 assaulted FC #5 at the facility. -She went out to the facility on 8/3/23 to initiate the DSS investigation. -She did inform the facility of the allegations of abuse against FS #4. -She made the Home Manager aware of the allegations on 8/3/23 when she visited the facility. -The allegations were from an incident on 7/12/23	V 366		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 20 that happened with FS #4 and FC #5. Review on 8/24/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against FS #4 related to him assaulting FC #5. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 8/24/23 with the Lead Qualified Professional revealed: -She was aware of DSS allegation of abuse against FS #4 that involved FC #5. -The Home Manager made her aware of the allegation of abuse on 8/3/23. -The incident supposedly happened on 7/12/23 with FS #4 and FC #5. -FC #5 went to the hospital due to a bruise he received on 7/7/23 during an incident with client #1. -The Home Manager told the DSS Social Worker there was a separate incident with client #1 and FC #5. -The DSS Social Worker was informed by the Home Manager client #1 bit FC #5 and they collided on 7/7/23 and that was why FC #5 went to the hospital on 7/12/23. -The allegation of abuse was not reported through IRIS because FS #4 was already terminated when the abuse allegation came to her attention on 8/3/23. -She confirmed the facility failed to implement a	V 366		

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 21 policy governing their response to Level III incidents as required.	V 366		
V 367	27G .0604 Incident Reporting Requirements 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 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	V 367		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 22 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 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	V 367		

PRINTED: 09/05/2023
FORM APPROVED

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
	MHL047-177	A. BUILDING: ______ B. WING ______	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY THERAPEUTIC SERVICES #14	6916 LAURENBURG 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 23 (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 record reviews and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Refer to V-366 regarding implementing a policy governing their response to Level III incidents. -The Department of Social Services reported an allegation of abuse to the agency on 8-3-23. The allegation of abuse was against former staff #4 related to him assaulting former client #5. -Review of the North Carolina Incident Reporting Improvement System (IRIS) revealed the Lead Qualified Professional failed to report the above incident to the LME/MCO within 72 hours.	V 367		

Appendix 1-B: Plan of Correction Form

Plan of Correction

Please complete all requested information and email completed Plan of Correction form to:

Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**Serenity Therapeutic Services, Inc.**	**Phone:**	**910-904-7147**
Provider Contact Person for follow-up:	**Darrin McNeill/ Administrator**	**Fax:**	**910-248-6116**
		Email:	**ceo@serenityts.com**
Address:	**6916 Laurinburg Rd., Raeford, NC 28376**		**Provider #: MHL-047-177**

Finding	Corrective Action Steps	Responsible Party	Timeline
V110 27G .0204 Training/Supervision Paraprofessionals **1. One of three audited former staff (FS #5) and one of two audited current staff (#1) failed to demonstrate the knowledge, skills, and abilities required for the population served.**	1. The CEO/director and QP conducted a refresher training with the House 14 staff on abuse, neglect, and exploitation on August 8, 2023. The home manager will provide in-service training to all new staff by ensuring a client specifics form is completed for each member in the home. The QP will facilitate ongoing training, as needed, related to the competency areas outlined in the applicable service definition(s) and individual supports plan. The HR manager will continue to ensure new staff are scheduled for and receive required agency trainings within established timelines per company policy. The HR manager will conduct monthly audits to ensure all staff have met the agency training requirements. The QP in conjunction with the home manager will continue to complete, at minimum, quarterly supervisions.	**Darrin McNeill**	**Implementation Date: August 30, 2023** **Projected Completion Date: September 30, 2023**
V 132 G.S. 131E-256(G) HCPR-Notification, Allegations, and Protection **1. The facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days.**	1. Former staff (FS #4) was terminated on 8/2/2023, prior to DSS' on-site visit and before the allegation of abuse; the client involved in the alleged allegation is no longer receiving services through Serenity. The QP will report all allegations of abuse, neglect, and exploitation, as needed, to the HCPR within the required timeframes. The QP will consult the Incident Response and Reporting Manual to ensure notification requirements are met to prevent future occurrences, as needed.	**Darrin McNeill**	**Implementation Date: August 30, 2023** **Projected Completion Date: August 30, 2023**
V 291 27G .5603 Supervised Living – Operations **1. The facility failed to ensure coordination was maintained between the facility operator and other qualified professionals who are responsible for treatment/habilitation or case management affecting one of one former clients. (FC #5).**	1. The QP will coordinate care with other qualified professionals (QPs) responsible for treatment/habilitation or case management, as needed, as well as other members of the treatment team, including but not limited to the LRP via email to keep a written account of all exchanges and to keep the team informed of any updates related to the client's care.	**Darrin McNeill**	**Implementation Date: August 30, 2023** **Projected Completion Date: August 30, 2023**
V 366 27G .0603 Incident Response Requirements **1. The facility failed to implement a policy governing their response to Level III incidents as required.**	1. The Agency has a policy on incident response requirements, including Level III incidents. The QP will continue to follow the Agency's policies and procedures and State's incident response requirements as outlined in the DHSR Incident Response and Reporting Manual for reporting Level III incidents, as needed. This will include but is not	**Darrin McNeill**	**Implementation Date: August 30, 2023** **Projected Completion Date: August 30, 2023**

	limited to, conducting an internal investigation, convening an internal review meeting within 24 hours, issuing preliminary findings to the Host and/or Home LME, if different, and notifying the LRP. The QP will consult the Incident Response and Reporting Manual to ensure incident response requirements are met to prevent future occurrences, as needed.		
V 367 27G .0604 Incident Reporting Requirements **1. The facility failed to ensure incidents were reported to the LME/MCO for the catchment area where services are provided within 72 hours of becoming aware of the incident.**	1. The Agency has a policy on incident reporting requirements, including Level III incidents. The QP will continue to follow the Agency's policies and procedures and State's incident reporting requirements as outlined in the DHSR Incident Response and Reporting Manual for reporting Level III incidents, as needed. This will include but is not limited to, submitting incidents to the Host and/or Home LME, if different, within 72 hours of becoming aware of the incident and notifying the LRP. The QP will consult the Incident Response and Reporting Manual to ensure incident reporting requirements are met to prevent future occurrences, as needed.	**Darrin McNeill**	**Implementation Date:** **August 30, 2023** **Projected Completion Date:** **August 30, 2023**

THERAPEUTIC SERVICES

Da'nah C. Steele, Qualified Professional
206 S. Stewart Street
Raeford, NC 28376
Office #: (910) 904-7147
Fax #: (910) 248-6116
Email Address: dsteele@serenityts.com

FAX

To: DHSR MH Licensure &Certification Section

From: Da'nah C. Steele, Lead QP

Attn: Kimberly Sauls

Fax #: 919-715-8078

Date: 9/15/2023

Re: POC MHL-047-177

Pages: pages including cover sheet

☐ Urgent x For review ☐ Please comment ☐ Please reply ☐ Please recycle

Comments:

Please see the attached POC for MHL-047-177.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

September 6, 2023

Darrin McNeill
Serenity Therapeutic Services, Inc.
206 S Stewart Street
Raeford, NC 28376

Re: Complaint Survey completed August 30, 2023
Serenity Therapeutic Services #14, 6916 Laurinburg Road, Raeford, NC 28376
MHL # 047-1777
E-mail Address: ceo@serenityts.com, dsteele@serenityts.com
Intakes #NC00205666, NC00205715, NC00206178, NC00206180

Dear Mr. McNeill:

Thank you for the cooperation and courtesy extended during the complaint survey completed August 30. 2023. The complaints were substantiated.

Enclosed you will find all deficiencies 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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 29, 2023.

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.
- 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 at 919-855-3822.

Sincerely,

Kimberly R Sauls

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Catrice Horton

Catrice Horton
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR@Alliancebhc.org
Terry Stanton, Director, Hoke County DSS
Pam Pridgen, Administrative Supervisor