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	MHL047-176	A. BUILDING: _____ B. WING _____	R-C 10/30/2024

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SERENITY THERAPEUTIC SERVICES #13	7042 LAURINBURG ROAD RAEFORD, NC 28376

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on October 30, 2024. The complaints were substantiated (intake #NC00223076, intake #NC00223080). A deficiency was 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 has a current census of 6. The survey sample consisted of audits of 3 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff will be identified using the letter of the facility and a numerical identifier.	V 000		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of	V 512		

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V 512	Continued From page 1 intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, one of three staff (Facility Manager) neglected to protect six of six clients (Clients #1 - #6) by failing to report abuse. The findings are: Review on 10/22/24 of Client #1's record revealed: -Admission date of 7/6/22. -Diagnoses of Mild Intellectual Developmental Disability; Schizoaffective Disorder; Post-Traumatic Stress Disorder; High Cholesterol. Review on 10/22/24 of Client #2's record revealed: -Admission date of 9/3/19. -Diagnoses of Intermittent Explosive Disorder; Bipolar Disorder; Mild Intellectual Developmental Disability; History of Type 2 Diabetes; Hypothyroidism; Gastroesophageal Reflux Disease. Review on 10/22/24 of Client #3's record revealed: -Admission date of 1/26/23. -Diagnoses of Pedophilia; Autistic Disorder; Cerebral Palsy - Unspecified; Acquired Hemophilia; Moderate Intellectual Disabilities; Major Depressive Disorder - Recurrent - Unspecified; Gastroesophageal Reflux Disease	V 512		

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V 512	Continued From page 2	V 512		

without Esophagitis; Allergic Rhinitis - Unspecified; Hyperlipidemia - Unspecified; Pain in Right Knee; Personal History (Past History) of Sexual Abuse in Childhood; Other Circumstances Related to Child Sexual Abuse.

Review on 10/22/24 of Client #4's record revealed:
-Admission date of 5/2/23.
-Diagnoses of Severe Intellectual Developmental Disability; Intermittent Explosive Disorder; Traumatic Brain Injury; Personality Change Due to Brain Injury; Tetralogy of Fallot - Congenital Heart Defect.

Review on 10/22/24 of Client #5's record revealed:
-Admission date of 10/11/22.
-Diagnoses of Mild Intellectual Developmental Disability; History of Other Paraphilic Disorder; History of Exhibitionist; Oppositional Defiant Disorder; Bipolar Disorder; Attention Deficit Hyperactivity Disorder - Combined Type.

Review on 10/22/24 of Client #6's record revealed:
-Admission date of 1/17/23.
-Diagnoses of Moderate Intellectual Developmental Disability; Down Syndrome.

Review on 10/22/24 of the Facility Manager's personnel record revealed:
-Date of hire was 10/18/19.
-Date of termination was 10/22/24.

Review on 10/22/24 of the Incident Response Improvement System (IRIS) report dated 8/16/24 revealed:
"On August 13, 2024, at approximately 8:15 am, [Client #1] came to the corporate office upset,

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V 512	Continued From page 3 stating that he was tired of a particular staff (FS #1). The QP (Qualified Professional) escorted [Client #1] and another staff member who was with him to the conference room and asked him to explain what caused him to be upset with the staff [FS #1]. [Client #1] stated that the staff [FS #1] was "starting with him" because he [Client #1] was asked not to intervene while the staff [FS #1] was trying to address a situation with another client (resident). [Client #1] then stated that he lied to the QP (Qualified Professional) last month about an incident that occurred in July that pertained to bruises that he had on his eyes, in which he initially reported to the QP that he stepped in between his housemate and a staff member while the housemate was having a physically aggressive behavior towards the staff. [Client #1] then said that he received the bruises because he got into a fight with the staff [FS #1]. The QP reminded [Client #1] of the importance of telling the truth because he initially reported that he did not have any altercation with a staff when questioned by the QP. [Client #1] then stated that he lied and that he and the staff [FS #1] got into a physical altercation because [Client #1] got upset after the staff [FS #1] told him he could not take chips and salsa in his bedroom, per the facility rule. [Client #1] then stated that during the altercation, the staff [FS #1] punched him in the nose, which caused his nose to start bleeding. [Client #1] stated that he then went next door to another Serenity (Licensee) group home [Sister Facility A], where a staff [Staff A1] member helped him stop his nose from bleeding. After this, the QP called the day program and asked the staff [FS #1] who worked during the weekend in question (July 7th) to come to the office. While waiting for the staff [FS #1] to come, the other staff [Staff A1] member who [Client #1] stated helped him stop his nose bleed at the time of the	V 512		

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V 512	Continued From page 4 incident from the other facility [Sister Facility A1] was called; however, the staff [Staff A1] stated that she had no knowledge of what [Client #1] was referring to and that she's never rendered first aid to [Client #1] since she's worked at that facility. The facility [Sister Facility A1] home manager [Staff A2] further confirmed that she was not aware of any of her staff rendering first aid to [Client #1] during the weekend in question or at any other time. Once the staff [FS #1] arrived at the office, the QP initially asked what happened this morning with [Client #1]. Each staff member, including [Staff #5], [Staff #6], and [FS #1], reported that another resident was not in the best mood this morning and that [Client #1] repeatedly tried to intervene as the staff was trying to redirect the other client. The staff reported that once they redirected [Client #1] to allow the staff to handle the incident, he became upset, threatened to fight the staff [FS #1], and stormed off to the office to talk to the QP. The QP then proceeded to ask the accused staff [FS #1] about an alleged altercation that happened between him and [Client #1] last month. [FS #1] stated that on Sunday, July 7, 2024, he saw [Client #1] attempting to take chips and salsa in his bedroom. [FS #1] stated that he verbally redirected [Client #1] and told him that he could eat the food, but that he could not take it to his room because it was the facility rule. [FS #1] then said [Client #1] got upset and became physically aggressive. [FS #1] said that he and [Client #1] were located in the facility's office area and that he [FS #1] was backed against the medication cart. [FS #1] said that he initially pushed [Client #1] away from him; however, he said that [Client #1] continued his aggression, so he slapped [Client #1] in the face. The QP asked [FS #1] if he received EBPI (Evidence Based Protective Interventions) training, which he confirmed he did. The QP also asked if anyone	V 512		

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V 512	Continued From page 5 else witnessed the incident, to which [FS #1] stated that the other staff on duty were outside with another resident (client) who was having an aggressive behavior at the time, and none of the other clients were around. The QP then asked the staff [FS #1] to write a statement and informed him that an internal investigation would take place, and asked him to clock out. [FS #1] refused to write the statement, and the QP instructed the HR (Human Resources) manager to clock him out; he left the premises without incident." Interview on 10/22/24 with Client #1 revealed: -He was involved in an incident with FS #1 "sometime in July (7/7/24)." -He had taken chips, dip, and soda to his bedroom. -FS #1 informed him that he could not have food in his bedroom. -He told FS #1 that he was going to keep the food and soda in his room because he purchased it. -FS #1 attempted to "snatch" the food and soda from him and he put it in his other hand. -FS #1 pushed his arm. -He told FS #1 not to push him and FS #1 pushed him again. -He pushed FS #1 back and FS #1 "snatched the chips, dip and soda" from his hand and went to the staff office. -He followed FS #1 and asked what he was going to do with his food. -He followed FS #1 into the staff office. -He and FS #1 argued and cursed at one another while in the staff office. -He and FS #1 pushed one another. -FS #1 punched him in the face and his nose bled. -He walked next door to Sister Facility A and Staff A1 assisted him with his nose bleed.	V 512		

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V 512	Continued From page 6 -He did not tell Staff A1 that FS #1 hit him in the face and caused his nose to bleed. -He could not recall the staff that were outside and observed him walking next door -He did not report the incident to any of the staff. -He did not tell the Facility Manager because he did not want the Facility Manager "to have to do a lot of paperwork." -He "later" informed the QP of the incident because he was "tired" of FS #1. -He did not explain reasons as to why he "was tired" of FS #1. -He could not recall the date he informed the QP of the incident. Interview on 10/22/24 with Client #2 revealed: -FS #1 would verbally redirect Client #1 and Client #1 would get "angry." -He observed Client #1 attempting to go in the staff office, but FS #1 "did not want him in there." -He did not know why Client #1 attempted to go in the staff office. -FS #1 punched Client #1 in the nose. -He could not recall the date or provide additional details regarding the incident. -He did not know if any other staff or clients witnessed the incident. Interview on 10/28/24 with FS #3 revealed: -Client #1 had "something in his room that he was not supposed to." -She recalled that client #1 had taken salsa and chips or a game controller in his room. -FS #1 had taken the salsa and chips from client #1. -Client #1 insisted that FS #1 return the salsa and chips. -Client #1 did not want FS #1 to redirect him. -Client #1 threatened and pushed FS #1. -FS #1 punched Client #1 in the nose.	V 512		

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V 512	Continued From page 7 -She "thought" the salsa and chip incident happened outside. -Client #1 came outside and yelled, threatened and approached FS #1 in a physically aggressive manner. -FS #1 slammed client #1 on the ground. -She observed Client #1 walking over to the sister facility. -She called the Facility Manager and informed him of the incident. -The Facility Manager came to the facility and got "everybody's story." -The reporting process was staff reported incidents to the Facility Manager. Interview on 10/25/24 with Staff #4 revealed: -She reported to work on third shift (7:00 p.m. - 7:00 a.m.) every other weekend. -She was scheduled to work at the facility on 7/7/24. -FS #1 and FS #3 were working first and second shift (7:00 a.m. - 7:00 p.m.) at the facility on 7/7/24. -The Facility Manager telephoned her "earlier" and asked her to come in a "little early" to assist with Client #4 because she was familiar with Client #4's behavior. -The Facility Manager informed her that he was on his way to the facility. -FS #1 "clocked out" and the Facility Manager arrived at the facility. -The Facility Manager inquired about what had taken place. -She informed the Facility Manager of the following: -She arrived at the facility "around 6:35pm," and saw that FS #1 was trying to "redirect and calm" Client #4 down while on the patio. -She advised FS #1 to usher the other clients back into the facility and she would assist Client	V 512		

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V 512	Continued From page 8 #4. -She redirected Client #4, escorted him into the facility, and to his room. -She observed that FS #1 walked towards the staff office. -She observed that Client #1 walked behind FS #1 in the same direction and toward the staff office. -Client #1 appeared "agitated" and she asked him "where he was coming from and what was wrong." -Client #1 stated, "This b***h right here is trying me (Client #1 was referring to FS #1)." -She walked into the dayroom area and told the other clients to go to their bedrooms. -She walked back toward the office because she heard FS #1 tell Client #1 to "Back up, you're not supposed to be in here." -She was "counter cornered" near the kitchen counter area and could see into the office. -She witnessed FS #1 in a corner of the office and Client #1 stood in front of him. -Client #1 said, "You wanted to sit here and try me, so let's go." -She heard Client #4 "exhibit a behavior" and left the kitchen area to assist him. -She calmed Client #4 down, heard a commotion, and walked towards the office. -FS #1 walked past her. -She turned around and Client #1 came out of the office with a nosebleed. -Client #1 "wasn't bleeding out or it wasn't like blood was pouring from his nose." -She asked FS #1 what happened, and he informed her that Client #1 had taken dip and chips that belonged to someone else. -FS #1 said that he "only" told Client #1 that he could not take someone else's chips and dip into his room. -FS #1 said that Client #1 followed him in the staff	V 512		

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V 512	Continued From page 9 office. -FS #1 stated that Client #1 "put his hands on him and he was trying to get him (Client #1) off of him." -FS #1 stated that he was "defending" himself from Client #1. -Staff A1 informed the Facility Manager that Client #1 was there and that she "got him cleaned up." -Staff A1 escorted Client #1 back to the facility. -She observed a "couple of small drops of blood" on the staff office floor. -She did not observe any marks or bruises anywhere on Client #1. -The Facility Manager asked Client #1 "why he had taken the chips when he knew they did not belong to him." -The Facility Manager asked Client #1 "why he didn't just give the chips and dip back" to FS #1 when he asked. -Client #1 told the Facility Manager that FS #1 "tried to take chips and dip from him." -She did not hear Client #1 tell the Facility Manager that FS #1 physically assaulted him. Interviews on 10/24/24 with Staff A1 revealed: -Client #1 came to Sister Facility A and he "had his hand over his nose." -She gave Client #1 a paper towel and he went back to his facility. -She could not recall if Client #1 informed her of what happened or why blood was on his nose. -She recalled that staff did not come in Sister Facility A with Client #1, but that staff could have been outside. Interview on 10/22/24 with Staff #2 revealed: -There was an incident which involved Client #1 and FS #1 that occurred on 7/7/24. -He was made aware of the incident on 8/13/24 during an internal investigation.	V 512		

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V 512	Continued From page 10 -Client #1 reported the incident to the QP on 8/13/24. -Client #1 "normally" reported incidents as they occurred. -Client #1 "probably did not report the incident because the altercation was initiated by him, and he did not want to hurt his chances of getting his cell phone back in his possession." Interview on 10/29/24 with the Facility Manager revealed: -He was not made aware of an incident that involved Client #1 and FS #1 on 7/7/24. -Client #1 did not "mention anything" about being physically assaulted by FS #1 on 7/7/24. -"None" of the staff told him about an incident involving Client #1 and FS #1 on 7/7/24. -He did not know why it would be reported that he was aware of an incident involving Client #1 and FS #1. -Staff #A1 disclosed that she did not provide medical attention to Client #1 during the internal investigation on 8/13/24. -He contacted FS #1 by telephone and informed him that he would come to the facility to pick up a client's paperwork. -He arrived at the facility after 7:00 p.m. and Client #4 was "in the middle of his behavior." -Staff #4 assisted Client #4. -FS #3 and Staff #4 were at the facility when he arrived. -FS #1 had left the facility. -He arranged work schedules for staff. -FS #1 was scheduled to work first shift Monday through Friday from 7:00 a.m. - 3:00 p.m., along with two to three additional staff at the facility. -FS #1 worked every other weekend and there were "at least" a total of two to three staff at the facility. -FS #1 was not "typically" scheduled to work with	V 512		

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V 512	Continued From page 11 Client #1. -The reporting process required that staff reported incidents to him and he reported incidents to the upper management (QP, Facility Operations Manager, and the Director). Interview on 10/22/24 with the QP revealed: -On 8/13/24, Client #1 informed her that FS #1 "kept starting with him." -Client #1 reported that he was upset because FS #1 was verbally redirecting him. -Client #1 stated that he took chips and salsa to his room. -Client #1 reported that FS #1 redirected him and told him that he could not take food in his room. -Client #1 stated that he got upset and that FS #1 got in his face and hit him. -Client #1 stated that FS #1 hit him in the nose. -Client #1 stated that he and FS #1 were the "only two in the office or office area." -Client #1 stated that he did not tell anyone. -FS #1 reported that he "hit or slapped him (Client #1) in the face." -FS #1 said that Client #1 "kept coming at him." FS #1's last day at work was on 8/13/24. FS #1 was terminated on 8/16/24. Interview on 10/28/24 with the QP revealed: -The reporting process required that staff reported incidents to the Facility Manager and the Facility Manager reported to someone in senior management (QP, Facility Operations Manager or the Director/Chief Executive Officer). -The Facility Manager or any of the staff did not report the incident that occurred on 7/7/24 to senior management. -There was a component in Client Rights training that taught staff to report incidents involving Abuse/Neglect/Exploitation. -FS #1 was on the schedule from 7/7/24 until	V 512		

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V 512	Continued From page 12 senior management was made aware of the incident on 8/13/24. Review on 10/30/24 of FS #1's time card revealed: -FS #1 worked at the facility from 7/7/24 through 8/13/24 for a total of twenty-seven days. Review on 10/30/24 of a Plan of Protection written by the QP dated 10/30/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? To immediately correct the above rule violations in order to protect clients from further risk or additional harm, abuse or neglect, the QP conducted a refresher training with House 13 (facility) staff on abuse, neglect, and exploitation on August 21, 2024. The QP will conduct a refresher training with House 13 staff on incident reporting requirements on October 30, 2024. Describe your plans to make sure the above happens. To immediately correct the above rule violations in order to protect clients from further risk or additional harm, abuse or neglect, the QP conducted a refresher training with the House 13 staff on abuse, neglect, and exploitation on August 21, 2024. The QP will conduct a refresher training with House 13 staff on incident reporting requirements on October 30, 2024. The QP will continue to facilitate ongoing training, as needed, related to the competency areas outlined in the applicable service definition(s) and individuals supports plan. The QP in conjunction with the home manager will continue to complete, at minimum, quarterly supervisions. The home manager, in conjunction with the operations manager, will conduct periodic reviews of the facility cameras to ensure that the health and safety of the individuals are carried out by the staff on duty. The HR (Human Resources)	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-176	A. BUILDING: _____ B. WING _____	R-C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 13 manager will ensure all newly hired staff receive all mandatory trainings, including but not limited to, clients' rights, incident reporting, and abuse, neglect, and exploitation, which is reviewed during the agency's Documentation and Competencies Training. The HR manager will continue to ensure all newly hired staff and staff receiving recertification, receive the mandatory agency trainings with established timelines, per company policy. The HR manager will continue to notify the home manager and senior management team of staff members who fail to attend the required trainings, at which time, the home manager will immediately remove the staff from the schedule until the training requirement is met. The HR manager will conduct monthly audits to ensure all staff have met the agency training requirements." Clients at the facility had diagnoses of: Mild Intellectual Developmental Disability; Schizoaffective Disorder; Post-Traumatic Stress Disorde; Intermittent Explosive Disorder; Bipolar Disorder; Pedophilia; Autistic Disorder; Cerebral Palsy - Unspecified; Moderate Intellectual Disabilities; Major Depressive Disorder - Recurrent - Unspecified; Personal History (Past History) of Sexual Abuse in Childhood; Other Circumstances Related to Child Sexual Abuse; Severe Intellectual Developmental Disability; Traumatic Brain Injury; Personality Change Due to Brain Injury; History of Exhibitionist; Oppositional Defiant Disorder; Bipolar Disorder; Attention Deficit Hyperactivity Disorder - Combined Type; Down Syndrome. There was an incident on 7/7/24 involving client #1 and FS #1. The incident began when Client #1 became angry because he could not take food into his room. FS #1 took the food away from Client #1 and placed it into the staff office. Client #1 followed FS #1	V 512		

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 512	Continued From page 14 into the staff office and the two began to push one another. FS #1 admittedly slapped Client #1 in the face. The incident was reported to the Facility Manager by FS #3 and Staff #4 when he came to the facility to address the incident on 7/7/24. Client #1 reported the incident to the QP on 8/13/24. The Facility Manager did not report the incident to management and FS #1 continued to work in the facility from the date of the incident for a total of twenty-seven days and until management was made aware of the incident on 8/13/24. This deficiency constitutes a Type A1 rule violation for neglect and must be corrected within 23 days.	V 512		