| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|---|--|---|--------------------------|--|------------------------------|--------------------------|
| MHL026-892 | | | B. WING | ING 06/ | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | • | |
| SERENIT | TY THERAPEUTIC SE | RVICES #3 | CKWOOD CC VILLE, NC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | on June 25, 2025. This facility is licens | w up survey was completed Deficiencies were cited. sed for the following service C 27G .5600C Supervised | | | | |
| | Living for Adults wit This facility is licens | h Developmental Disability. sed for 3 and currently has a urvey sample consisted of | | | | |
| V 112 | 27G .0205 (C-D) Assessment/Treatn | nent/Habilitation Plan | V 112 | | | |
| | Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
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| | | A. BOILDING. | | R | | | |
| | | MHL026- | 892 | B. WING | | | 5/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| SERENIT | TY THERAPEUTIC SE | RVICES #3 | | KWOOD CO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T | ULD BE | (X5) COMPLETE DATE |
| V 112 | Continued From pa | age 1 | | V 112 | | | |
| | This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement strategies to meet the individual needs of 1 of 3 audited clients (#1). The findings are: Review on 6/24/25 of client #1's record revealed: -Date of admission: 6/1/10Diagnoses: Asperger's Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Generalized Anxiety Disorder, Obesity, Gastroesophageal Reflux Disease, Sleep Apnea and Allergic RhinitisTreatment Plan dated 5/1/25 and updated 5/20/25 did not contain strategies for property | | | | | | |
| | Interview on 6/24/2 -"The tile got pushe at it. It needs to be if it was fixed. I ne been kicking the w I keep doing it." -He did not know w | ed in, I pushed i fixed again. I do ed to stop dama all for awhile. I | t. I was kicking on't remember aging it. I have don't know why | | | | |
| | Interview on 6/24/2 -He worked one or -Client #1 continue after facility got it re -He didn't know wh wallClient #1 goals we | one with client d to destroy the epaired. y he continued | #1. bathroom wall to destroy the | | | | |

Division of Health Service Regulation

STATE FORM 6899 S8FV11 If continuation sheet 2 of 6

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|------------------------------|--|
| MHL026-892 | | | B. WING | B. WING 06 | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET / | ADDRESS, CITY, | STATE, ZIP CODE | | |
| SERENI | TY THERAPEUTIC SE | RVICES #3 | CKWOOD CO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | (X5) COMPLETE DATE | |
| | Interview on 6/24/29 -Client #1 continued the bathroom wall. | outer time and return back to 5 the Lead worker stated: d to "pick at it" and damage repaired twice since last yea | г. | | | |
| | Interview on 6/24/25 the House Manager stated: -Client #1 had "an issue" with damaging the wallShe was not sure why he continued to damage the wallMaintenance had last repaired the wall 4/2/25 and client #1 damaged it since then. | | | | | |
| | Interview on 6/24/25 the Qualified Professional (QP) stated: -"Staff should be monitoring him (client #1) 24/7, he is doing it (damaging the bathroom wall) while he is in the shower." -She had addressed with the House Manager to make make sure client #1 was being monitored while in the shower. "To my understanding this was being done." -She was responsible for developing the residential goals in the treatment planShe would update the treatment plan to address strategies for client #1 picking the tile off the bathroom wall. | | | | | |
| | -The QP would ens treatment plan to ac property destructior -An updated would | 5 the Director stated: ure strategies were in the ddress client #1's needs with n of the bathroom wall. be made to the current ddress the concern of propert | У | | | |

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Division of Health Service Regulation STATE FORM

S8FV11 If continuation sheet 3 of 6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | . I`´ | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|--|--------------------------------|--------------------------|
| | | MHL026-892 | B. WING | B. WING | | |
| | PROVIDER OR SUPPLIER TY THERAPEUTIC SE | RVICES #3 229 | EET ADDRESS, CITY, S 9 DOCKWOOD CO 'ETTEVILLE, NC 2 | DURT | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 736 | Continued From pa | ge 3 | V 736 | | | |
| V 736 | 27G .0303(c) Facili | ty and Grounds Maintena | nce V 736 | | | |
| | 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. | | | | | |
| | | on and interview, the faci in a safe, clean and attra | • | | | |
| | Observation on 6/24/24 between 9:47 am - 10:09 am during a tour of the facility revealed: -The bathtub in the hall bathroom had missing approximately 18-20 tiles around the water faucet, exposing wood and plastic bags. The real of the bathtub had a single row of missing tiles the length of the rear of the bathtub exposing wood frame. | | ng e rear es | | | |
| | -Staff reported dam and she submitted | 5 staff #1 stated: ed the tiles off the wall. age to the House Manag a maintenance request. d to damage the wall after | | | | |
| | -Client #1 continued the wall. -The wall had been -Staff notified the H she would submit a Interview on 6/24/2 | 5 the Lead Staff stated: d to "pick at it" and damage repaired twice since last ouse Manager of repairs maintenance request. 5 the House Manager stacked at the tiles until they | year. and | | | |

Division of Health Service Regulation

STATE FORM 6899 S8FV11 If continuation sheet 4 of 6

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|---|---|-----------------------------------|--------------------------|
| MHL026-892 | | | B. WING | | | R 06/25/2025 | |
| | PROVIDER OR SUPPLIER TY THERAPEUTIC SE | RVICES #3 | 2299 DO | DDRESS, CITY, S CKWOOD CO VILLE, NC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF | D BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 736 | Continued From paragraph - "This had been and than a year." -She had submitted repairsThe last maintena 4/2/25, the wall was by client #1Maintenance plant material" to preven off. Interview on 6/24/2 stated: -Client #1 continued damaged the tileThe House Managraph - The last work order last year 's DHSR's - Client #1 had since - To prevent further covering will be inspicking at the tileThe Operations M licensed contractor capabilities of the interview on the interv | on-going proble d a maintenance nce order was sub- ned to put a "har t client #1 from p 25 the Qualified I d picked at the was submitted a rewas submitted a re er was submitted 5 the Director staguest was submit ously been repair survey. e damaged the was damage, a plast talled to deter the anager assigned talled to deter the anager assigned the repair was n-house mainten imates the new i d within 5-7 days er properly mainta | orders for ubmitted on amaged again of plastic coulling the tile. Professional vall which maintenance 4/2/25. ated: tted by the fired following vall again. ic one-piece e client from the task to a beyond the fance worker. Installation is meet fained going of deficiency of deficiency of deficiency of deficiency and deficiency of defic | V 736 | | | |

Division of Health Service Regulation
STATE FORM

6899 S8FV11 If continuation sheet 5 of 6

PRINTED: 07/14/2025

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ R B. WING _ MHL026-892 06/25/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2299 DOCKWOOD COURT **SERENITY THERAPEUTIC SERVICES #3 FAYETTEVILLE, NC 28306** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Division of Health Service Regulation