Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		mhl043-039		B. WING		R- 01/0	-C 06/2020	
NAME OF	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SIERRA'S RESIDENTIAL SERVICES GROUP HI 21 LANEXA LANE SPRING LAKE, NC 28390								
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		
V 000	00 INITIAL COMMENTS			V 000				
	on January 6, 2020 unsubstantiated (indeficiency was cited	low up survey was control in the complaint was take #NC00158590) d.	. A					
		C 27G .1700 Reside						
V 736	27G .0303(c) Facili	ty and Grounds Mair	ntenance	V 736				
	EXTERIOR REQUI (c) Each facility and maintained in a safe	303 LOCATION AND REMENTS I its grounds shall be e, clean, attractive at e kept free from offe	nd orderly					
	failed to ensure fac	et as evidenced by: on and interview, the ility grounds were ma I attractive manner.	aintained					
		/20 at 10:10 AM of th ge/playing room reve e dark water stain.						
	area revealed: -Closet door by the wood and also had punched inThere was a baset	/20 at 10:15 AM of the front door had a hole a section that had be call size hole on the for made by the door	e in the een wall					

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	mhl043-039		B. WING			R-C 01/06/2020	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SIERRA'	S RESIDENTIAL SER	VICES GROUP HO	21 LANEX SPRING L	(A LANE .AKE, NC 28	3390		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	-Plastic cap on the broken. Observation on 1/6 leading to the room -The return vent on was very dirty with observation on 1/6 (First to the right of -Patched repairs or overPatched repair on exposing plasterThere was a hole of the inside bedroom #1 -Linoleum flooring of the home of the patched repairs or down and painted of the patched repairs or down and painted of the patched repairs or down and painted of the patched revealed of the patched revealed of the patched revealed of the patched revealed of the patched of t	wall for the TV cable /20 at 10:20 AM of the revealed: the ceiling for the ailint/dust. /20 at 10:22 AM of behallway) revealed: newalls had not been wall had been punched by the closet door. /20 at 10:25 AM of berevealed: was peeling off by the revealed: was peeling off by the revealed: newalls had not been by the revealed: new the revealed	ne hallway r condition edroom#1 painted ned in athroom e tub. edroom sanded ne hallway very ager ntenance a former	V 736	DEFICIEN		
		acility failed to ensur tained in a safe, clea					

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STATE FORM 6899 DVTO11 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CI	LIA ER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY		
		mb10.42.020		B. WING			-C		
NAME OF I	PROVIDER OR SUPPLIER	mhl043-039	REET ADI		STATE ZIP CODE	01/0	06/2020		
SIERRA'S RESIDENTIAL SERVICES GROUP HE 21 LANEXA LANE									
(X4) ID	SPRING LAKE, NC 28390								
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION	L N)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE		
V 736	Continued From pa	ge 2		V 736					
	attractive and order	ly manner.							

6899

Division of Health Service Regulation STATE FORM