

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>mhl043-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>09/03/2020</b> |
|--|---|---|---|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SIERRA'S RESIDENTIAL SERVICES GROUP H</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>21 LANEXA LANE</b><br><b>SPRING LAKE, NC 28390</b> |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| V 000              | <p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on September 3, 2020. The complaint was unsubstantiated (intake #NC00168636). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> | V 000         |   |                    |

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