STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl043-050	A. BUILDING: _____ B. WING _____	R-C 03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA'S RESIDENTIAL SERVICES GROUP H(	665 LAKE RIDGE DRIVE CAMERON, NC 28326

(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 and follow up survey was completed on March 30, 2021. The complaint was unsubstantiated (intake #NC00175256). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents	V 000		
V 112	27G .0205 (C-D) 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.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based record review and interviews the facility failed to ensure one of one client (FC #3) had strategies to address her needs and behaviors. The findings:

Review on 3/22/21 of FC #5's record revealed:
-Admission date of 6/15/20.
-Diagnoses of Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder
-Discharge date of 1/8/21.
-FC #5 had a history of biting his fingernails.
-Person Centered Plan dated 1/4/21 had no strategies to address FC #5 biting his fingernails.

Interview with staff #1 on 3/25/21 revealed:
-FC #5 had a history of fingernail biting.
-When she worked with FC #5 during the day she had to constantly tell him to stop biting his fingernails.
-She confirmed FC #5 had no strategies in his treatment plan to address biting his fingernails.

Interview with staff #2 on 3/25/21 revealed:
-FC #5 had a history of fingernail biting.
-FC #5 was constantly biting his fingernails.
-They started putting gloves on FC #5's hands.
-This was a suggestion from his physician.
-FC #5's nails looked bad, they were a pinkish color.
-It was daily prompts by staff for FC #5 to stop biting his fingernails.
-They constantly told FC #5 to stop biting his fingernails.

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V 112	Continued From page 2 -She confirmed FC #5 had no strategies in his treatment plan to address biting his fingernails. Interview with the Qualified Professional on 3/23/21 revealed: -FC #5 had a history of fingernail biting. -FC #5's nails were low and a whitish color. -She thought when FC #5 got a little nervous or bored, he would do more of the fingernail biting. -She thought he went to his physician the end of December 2020 or January 2021 about the fingernail biting. -The doctor recommended FC #5 wear latex gloves. -She thought the issue with the fingernail biting started getting worst in December 2020. -She confirmed FC #5 had no strategies in his treatment plan to address biting his fingernails. Interview on 3/29/21 with the Clinical Director/Licensee revealed: -FC #5 had a history of biting his fingernails. -He thought FC #5 went to the physician regarding his fingernail biting. -He was not sure if FC #5 had anything in his treatment plan to address the nail biting.	V 112		
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	V 132		

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V 132	Continued From page 3 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 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 allegations of abuse were reported to the North Carolina Health Care	V 132		

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V 132	Continued From page 4 Personnel Registry (HCPR) of the Division of Health Service Regulation within five working days affecting one of one former client (FC #5). The findings are: Review on 3/22/21 of FC #5's record revealed: -Admission date of 6/15/20. -Diagnoses of Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder -Discharge date of 1/8/21. -FC #5 had a history of biting his fingernails. Review on 3/30/21 of the facility's personnel files revealed: -Staff #1 had a hire date of 8/25/20. -Staff #1 was hired as a Paraprofessional. Review of facility records on 3/22/21 revealed: An internal agency investigation dated 1/29/21 had the following: "On 1/27/21 [the Clinical Director/Licensee] of SRS (Sierra's Residential Services, Inc. was contacted by [Investigating Social Worker]. [The Investigating Social Worker] informed [the Clinical Director/Licensee] that another allegation was made by all consumers located [address for group home]. Allegedly, [Staff #1] poured hot sauce on [FC #5's] fingernails..." Review of facility records on 3/22/21 revealed: -There was no documentation the facility reported the above allegation of abuse to North Carolina HCPR. Interview with the Qualified Professional on 3/23/21 revealed: -There was an allegation of abuse brought to there attention by the Investigating Social Worker. -The incident came to their attention towards the end of January 2021.	V 132		

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V 132	Continued From page 5 -The Clinical Director/Licensee, Office Administrator and herself conducted an investigation. -The Investigating Social Worker informed them staff #1 was seen putting hot sauce on FC #5's fingers. -The Investigating Social Worker said staff #1 was using the hot sauce as a form of punishment due to FC #5's fingernail biting. -FC #5 does had a history of fingernail biting. -She did not report that incident to North Carolina HCPR. -She thought the Office Administrator possibly reported that incident to North Carolina HCPR. -The Office Administrator was responsible for reporting incidents to North Carolina HCPR. -She confirmed the agency had not reported the alleged incident of abuse to North Carolina HCPR within five working days. Interview with the Office Administrator on 3/23/21 revealed: -They were not sure how to handle the situation when the hot sauce allegation was brought to their attention. -Another Surveyor came out in January 2021 to investigate an improper Restrictive Intervention. -They thought that Surveyor's investigation included the incident about the hot sauce with FC #5. -They did not realize the 2 incidents were separate. -They thought the hot sauce and Restrictive Intervention incidents were combined. -She did not report the allegation of abuse to North Carolina HCPR. -She confirmed the agency had not reported the alleged incident of abuse to North Carolina HCPR within five working days.	V 132		

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V 132	Continued From page 6 Interview with the Clinical Director/Licensee on 3/29/21 revealed: -The investigating Social Worker brought the hot sauce issue to their attention. -He could not remember the exact date it was brought to their attention. -Initially, the investigating Social Worker would not give him any information regarding the hot sauce issue. -He called back the next day with the Qualified Professional and Office Administrator on conference call and spoke with the investigating Social Worker. -The Investigating Social Worker gave them more information during the conference call. -The investigating Social Worker said during her investigation a client reported staff #1 put hot sauce on FC #5's fingers. -They did an internal agency investigation. -He did not report the incident to North Carolina HCPR. -It was not reported to North Carolina HCPR because based on their conclusive evidence the incident was unsubstantiated. -He confirmed the agency had not reported the alleged incident of abuse to North Carolina HCPR within five working days.	V 132		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be	V 318		

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V 318	Continued From page 7 submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record review and interviews the facility failed to report an allegation of abuse to Health Care Personnel Registry within 24 hours of becoming aware of the allegation. The findings are: Refer to V-132 for specific details.	V 318		
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:	V 367		

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V 367	Continued From page 8 (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 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	V 367		

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V 367	Continued From page 9 .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 (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 LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 3/22/21 of FC #5's record revealed: -Admission date of 6/15/20. -Diagnoses of Post Traumatic Stress Disorder	V 367		

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V 367	Continued From page 10	V 367		

and Disruptive Mood Dysregulation Disorder
-Discharge date of 1/8/21.
-FC #5 had a history of biting his fingernails.

Review on 3/30/21 of the facility's personnel files revealed:
-Staff #1 had a hire date of 8/25/20.
-Staff #1 was hired as a Paraprofessional.

Interview with the Qualified Professional on 3/23/21 revealed:
-There was an allegation of abuse brought to there attention by the Investigating Social Worker.
-The incident came to their attention towards the end of January 2021.
-The Clinical Director/Licensee, Office Administrator and herself conducted an investigation.
-The Investigating Social Worker informed them staff #1 was seen putting hot sauce on FC #5's fingers.
-The Investigating Social Worker said staff #1 was using the hot sauce as a form of punishment due to FC #5's fingernail biting.
-FC #5 does had a history of fingernail biting.
-She did not do the Incident Response Improvement System (IRIS) report for the hot sauce allegation.
-She thought the Office Administrator possibly did the IRIS report.
-The Office Administrator was responsible for completing the IRIS reports.
-She would occasionally a report in IRIS.
-The Office Administrator was always in office and had access to the paperwork.
-She confirmed the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required.

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V 367	Continued From page 11 Interview with the Office Administrator on 3/23/21 revealed: -They were not sure how to handle the situation when the hot sauce allegation was brought to their attention. -Another Surveyor came out in January 2021 to investigate an improper Restrictive Intervention. -They thought that Surveyor's investigation included the incident about the hot sauce with FC #5. -They did not realize the 2 incidents were separate. -They thought the hot sauce and Restrictive Intervention incidents were combined. -She did not do a report in the Incident Response Improvement System (IRIS) for the hot sauce allegation. -She confirmed the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. Interview with the Clinical Director/Licensee on 3/29/21 revealed: -The investigating Social Worker brought the hot sauce issue to their attention. -He could not remember the exact date it was brought to their attention. -The investigating Social Worker said during her investigation a client reported staff #1 put hot sauce on FC #5's fingers. -Initially, the investigating Social Worker would not give him any information regarding the hot sauce issue. -He called back the next day with the Qualified Professional and Office Administrator on conference call and spoke with the investigating Social Worker. -The Investigating Social Worker gave them more information during the conference call.	V 367		

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V 367	Continued From page 12 -They did an internal agency investigation. -They did not do an incident report in IRIS because they did an internal investigation. -The incident never happened, he felt like an incident report was not necessary. -He confirmed the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 3/23/21 at approximately 11:36 am of the group home revealed the following: -Dining room area-There was a quarter sized hole in the wall. There were stains on the walls. -Den area-There was a hole in the wall approximately the size of a plum near the front door. The ceiling had a water stain. There were approximately 11 nail holes in the walls. -Bathroom #1-There were approximately 6 small holes in wall.	V 736		

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V 736	Continued From page 13 -Laundry room area-The walls were stained. -Hallway area-The walls were stained. -Bathroom #2-There was a set of broken blinds. -Client #3's bedroom-The walls were stained. -Client #2's bedroom-The inside of closet walls were stained. Interview with the Qualified Professional on 3/23/21 revealed: -She was not sure why the ceiling in the den area was stained. -She thought the stain on the ceiling was there for about 30 days. -The small holes in the walls in the den area was caused by nails. -They took the pictures off the walls and had the walls painted. -They had the walls painted throughout the group home about a month ago. -They were aware of most of the issues with the group home. -They already put in work orders for some of the maintenance issues. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		