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-C B. WING mhl043-050 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 665 LAKE RIDGE DRIVE SIERRA'S RESIDENTIAL SERVICES GROUP HO CAMERON, NC 28326 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 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 112 27G .0205 (C-D) V 112 Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE (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

TITL

(X6) DATE

STATE FORM

900

If continuation sheet 1 of 14



MCES INCORPORA				
Division of Health Service Regulation	on T			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUI	MBR:	(X2) Multiple Construction A. Building: 01 B. WING	(X3) DATE SURVE COMPLETED 04/12/2021
NAME O	F PROVIDER:		STREET ADDRESS, CITY, STATE, ZIP CODE	
SIERRA'S RESIDE	NTIAL SERVICES, INC.		665 LAKE RIDGE DRIVE CAMERON, NC 28326	
SIERRA'S RESIDENTIAL SERVICES, INC. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 000 INITIAL COMMENTS V 000 A complaint and follow up survey was completed on March 30, 2021. The complaint was unsubstantiated (intake #NC00175256). Deficiencies were cited. 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 000	Indicate what measures will be put in place to <i>correct</i> the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.). Indicate what measures will be put in place to <i>prevent</i> the problem from occurring again. Indicate who will monitor the situation to ensure it will not occur again. Indicate how often the monitoring will take place. Sierra's Residential Services' Qualified Professional, QP will assure that the Consumer(s) PCP is/are updated as needed to address Strategies/Interventions and Needs. The PCP(s) will also include the Consumer'(s) Primary Care Physician recommendation to all treatment Plans. The Office Administrator will conduct Medical Record Audits on a Random Basis to ensure compliance. assure that all PCP have the Physicians	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

(X6) DATE

STATE FORM JOHN GEN, CEW

FE6922

/If continuation sheet 1 of 1



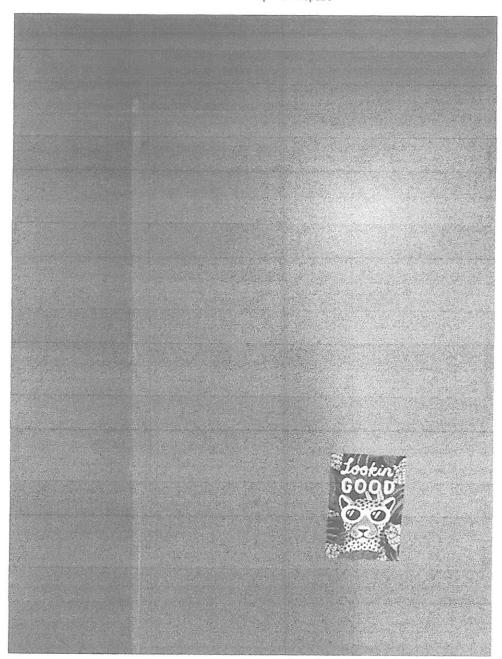
Division of Health Service Regulation)			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUM MHL # 043-050	MBR:	(X2) Multiple Construction A. Building: 01 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2021
NAME OF	PROVIDER:		STREET ADDRESS, CITY, STATE, ZIP CODE	04/12/2021
SIERRA'S RESIDEN			665 LAKE RIDGE DRIVE CAMERON, NC 28326	
SIERRA'S RESIDENTIAL SERVICES, INC. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET E
failed to ensure one of strategies to address V 132 G.S. 131E-256(G) HO Allegations, & Protect G.S. §131E-256 HEA REGISTRY (g) Health care faciliti Department is notified health care personne unknown source, whi any act listed in subd (which includes: a. N in a healthcare This Rule is not met a Based on record revie facility failed to ensure	and interviews the facility of one client (FC #3) had his needs and behaviors. CPR-Notification, tion ALTH CARE PERSONNEL ies shall ensure that the d of all allegations against el, including injuries of ch appear to be related to ivision (a)(1) of this section. leglect or abuse of a resident	V 132	Sierra's Residential Services' Qualified Professional and Office Administrator will notify and submit a report of Incident and Findings to the NC Healthcare Personal Registry (HCPR) regarding any Allegation of Neglect or Abuse that has been made by a Consume(s) and/or Staff Member(s) within 1-5 Business Days of finding out about an Allegation(s). Office Administrator or Designee will conduct Incident Reporting Record, Medical Record, and/or Personnel Record Audits on a Random Basis to ensure compliance.	04/12/2021
REPORTING HEALT The reporting by healt Department of all alles personnel as defined including injuries of ur done within 24 hours becoming aware of th	4 Hour Reporting 2 INVESTIGATING AND 14 CARE PERSONNEL 15 th care facilities to the 16 gations against health care 16 in G.S. 131E-256 (a)(1), 17 nknown source, shall be 18 of the health care facility 18 e allegation. The results of 19 investigation shall be		Sierra's Residential Services' Qualified Professional and Office Administrator will notify/report to the NC Healthcare Personnel Healthcare Registry (HCPR) regarding any Allegation of Abuse within 24 Hours becoming aware of the Allegation. Office Administrator or Designee will conduct Incident Reporting Record, Medical Record, and/or Personnel Record Audits on a Random Basis to ensure compliance.	



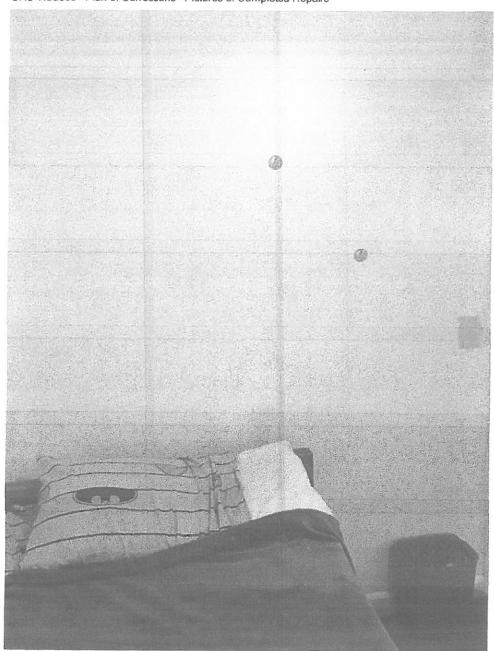
n			
PROVIDER IDENTIFICATION NUM	MBR:	(X2) Multiple Construction A. Building: 01 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2021
		STREET ADDRESS, CITY, STATE, ZIP CODE	
NTIAL SERVICES, INC.		665 LAKE PINGE DRIVE CAMEDON NC 20226	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
epartment in accordance with et as evidenced by: eview and interviews the facility allegation of abuse to Health egistry within 24 hours of the allegation	V 337	Sierra's Residential Services' Qualified Professional will report All Level II Incident Reports to the LME for the catchment area where services are provided within 72 hours of becoming aware of the Incident. Office Administrator or Designee will conduct Audits of SRS' Incident Reporting Record(s), Medical Record(s), and/or Personnel File(s) on a Random Basis to	04/12/2021
	MHL # 043-050 F PROVIDER: NTIAL SERVICES, INC. IENT OF DEFICIENCIES ST BE PRECEDED BY FULL	PROVIDER IDENTIFICATION NUMBR: MHL # 043-050 F PROVIDER: NTIAL SERVICES, INC. JENT OF DEFICIENCIES ST BE PRECEDED BY FULL JENTIFYING INFORMATION) Age 2 Repartment in accordance with At as evidenced by: Eview and interviews the facility allegation of abuse to Health registry within 24 hours of The allegation Reporting Requirements AD B PROVIDENT UIREMENTS FOR DB PROVIDERS B providers shall report all Recept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients are rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the port may be submitted via mail, or encrypted electronic shall include the following The services of the incidents were reported to comment area where services The incidents were reported to comment area where services To hours of becoming aware	PROVIDER IDENTIFICATION NUMBR: MHL # 043-050 B. WING



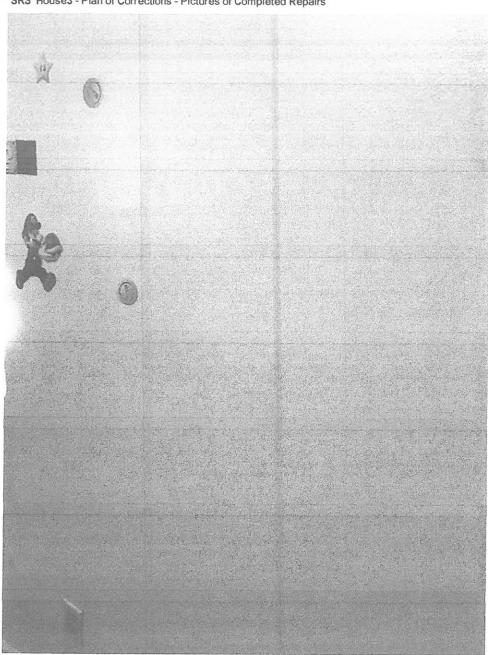
Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUM MHL # 043-050	//BR:	(X2) Multiple Construction A. Building: 01 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2021	
NAME C	PROVIDER:		STREET ADDRESS, CITY, STATE, ZIP CODE		
SIERRA'S RESIDE	NTIAL SERVICES, INC.	665 LAKE RIDGE DRIVE CAMERON, NC 28326			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
10A NCAC 27G .0303 EXTERIOR REQUIRE (c) Each facility and its maintained in a safe, of manner and shall be knoder. This Rule is not met a V 736. Based on obsert facility failed to ensure maintained in a safe, of manner The findings	EMENTS s grounds shall be clean, attractive and orderly kept free from offensive s evidenced by: rvation and interview, the	V 736	The repairs regarding of the aforementioned were completed by SRS' Maintenance Person on 04/12/2021. All Maintenance orders will be immediately turned into the office and will be completed within 72 hours of the office upon receiving a work order. Group Home Manager, QP or Designee will conduct safety checks on a Daily Basis. Office Personnel will conduct Random checks on Quarterly Basis to ensure compliance. Please see Attachment.		



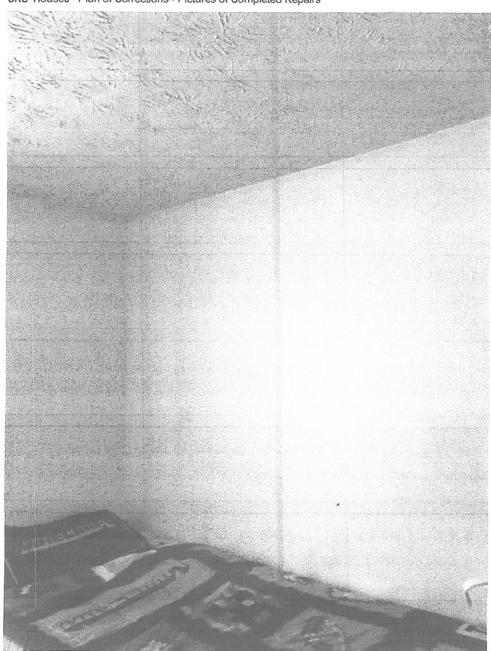
SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



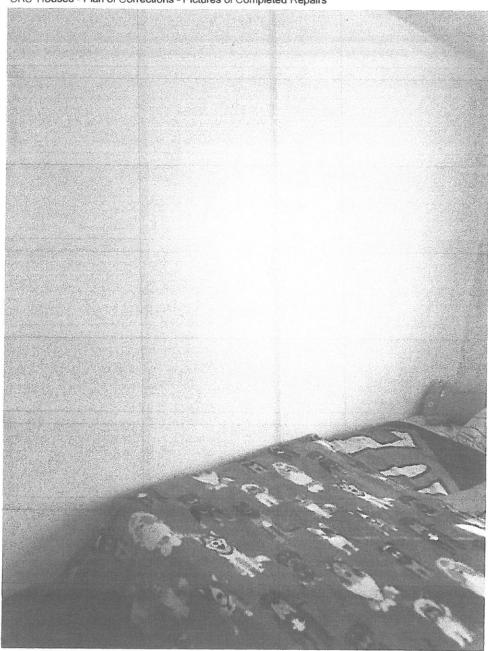
SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



SRS' House3 - Plan of Corrections - Pictures of Completed Repairs



