Division of Health Service Regulation

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		mhl043-039	B. WING		11/23/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	A LANE		
OILITITA O	REGIDENTIAL CERTICE	SPRING LA	AKE, NC 28390)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	00 INITIAL COMMENTS		V 000		
	completed 11/23/21.	, and follow up survey was The complaint (Intake # nsubstantiated. Deficiencies			
		d for the following service 27G .1700 Residential re for Children or			
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108		
	V 108 27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.				

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	•
				7 20.22		R	
		mhl043-039		B. WING		11/23/202	:1
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE	-	
	10115211 011 001 1 2.2.1		21 LANEXA	, ,	, 2 3332		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2		KE, NC 28390	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETE DATE
V 108	Continued From page	: 1		V 108			
	reporting, investigatin	d procedures for identif g and controlling infecti seases of personnel an	ous				
	failed to ensure three	ew and interview the fac of three audited staff (# ing to meet the MH/DD/	[‡] 5,				
	- Date of Adm - Age: 13 - Diagnoses: 0 Onset Type, Attention Disorder (ADHD), Col Mental Health Service Non-parental Child Se for Mental Health Ser Sexual Abuse by Pare - Treatment pl placement identified a signed 11/3/21: "[Clie	mbined Type, Encounte es for Perpetrator of exual Abuse and Encou- vices for Victim of Child ent lan goal #3 from previous as goals for current facilint #1] will refrain and dis f Involvement in probler	hood or for nter us ity splay				
	with family dog c). Distorted beliefs al and manipulation d). Taught at a early a in illicit sexual activity caught		recy lage				

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STATE FORM 8899 XOJN11 If continuation sheet 2 of 29

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				_		R
		mhl043-039		B. WING		11/23/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CIEDDAIC	DESIDENTIAL SERVICE	S CROUD HOME #3	21 LANEXA	LANE		
SIERRA S	RESIDENTIAL SERVICE	:5 GROUP HOME #2	SPRING LA	KE, NC 28390	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 108	Continued From page	e 2		V 108		
V 100	school, and f). Sneaking on the insecurity settings to accept the security settings the security security settings the security settings the security	ternet and bypassing coess child pornographys not connected to the ating knowledge of thy sexuality for adolesce next 60 days as evideol reports, Level III orts and his Legal Guard g therapeutic leave." 1 of staff #5's record 27/19 In dealing with adolesce tive behavior. staff #5 reported: In dealing with adolesce tive behavior. shift 1 of staff #6's record 1/1/7 In dealing with adolesce tive behavior. staff #6 reported: It arious trainings during its. 1 of staff #7's record 1/28/16 In dealing with adolesce tive behavior.	cents ence dian's ents ents their			
	Interview on 11/16/21 (QP) reported:	the Qualified Profession	onal 			

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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		mhl043-039	B. WING		R 11/23/2021
NAME OF PI	ROVIDER OR SUPPLIER	Sī	FREET ADDRESS, CITY, ST	ATE, ZIP CODE	
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	I LANEXA LANE PRING LAKE, NC 283	90	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETE DATE
V 108	training topics are pre They have he behavior training, cristraining on self injurio He was una for the sexually aggreintervention training a behaviors. Interview on 11/17/21 reported: They have aggressor training, but as possible." The facility's Intervention (NCI) Trafacilitate sexually aggree There is no predator training. Review on 11/16/21 of Minutes from January revealed:	nonthly staff meetings wheresented. and sexually aggressive sis intervention training and us behaviors. ble to provide training date essive behavior, crisis and training on self injurious. the Administrator Assistant had much sexual ut planned to add it as soo is Nonviolent Crisis ainer was approached to pressive behavior training, date scheduled for the sexual	d es s nt		
V 109	10A NCAC 27G .0203 QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be not qualified professional (b) Qualified profess professionals shall de and abilities required (c) At such time as a	SSIONALS privileging requirements to some associate professional and associate emonstrate knowledge, skin by the population served. competency-based sestablished by rulemaking privilemaking servel.	als. Ils		

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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING: _			Б
		mhl043-039	B. WING		l l	R / 23/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
		21 LANE	XA LANE	. L, Lii 005L		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	LAKE, NC 2839	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From page	e 4	V 109			
V 100	professionals shall de (d) Competence sha exhibiting core skills i (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal skil (6) communication s (7) clinical skills. (e) Qualified professi NCAC 27G .0104 (18 met the requirements employment system i MH/DD/SAS. (f) The governing bod develop and impleme for the initiation of an plan upon hiring each (g) The associate prosupervised by a quali	emonstrate competence. Il be demonstrated by ncluding: dge; ss; ss; ss; ss; skills; and sionals as specified in 10 A sp(a) are deemed to have of the competency-based in the State Plan for dy for each facility shall ent policies and procedures individualized supervision associate professional. of specified professional with the fied professional with the the period of time as				
	Qualified Professiona	n, record review and failed to ensure 1 of 1 Il (QP) demonstrated the abilities required by the				
		/16/21-11/17/21 the QP				

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S	
				A. BUILDING		_	
		mhl043-039		B. WING		11/2	₹ !3/2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA SPRING LA	ALANE AKE, NC 28390	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
V 109	Continued From page	÷ 5		V 109			
	revealed:	the home is a clean, satisfance." Insing checklist on a week and training of associate Professional and Is and others who have ressing the needs identified Plan. If the facility's Staffing eduled on site Monday, and Friday 8 am-6 pm; of client #1's record ission: 11/10/21 Conduct Disorder, Childle Deficit Hyperactivity mbined Type, Encounters for Perpetrator of exual Abuse and Encouvices for Victim of Child ent of client #2's record ission: 2/19/21 Post Traumatic Stress	e ed, fe, ekly nd a ffied				
	Age: 13Diagnoses: I		ive				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION	(X3) DATE S COMPL	
		mhl043-039		B. WING		F	R 3/2021
		11111043-039				11/2	3/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA	LANE KE, NC 2839	2		
	CUMMADVCT	ATEMENT OF DEFICIENCIES	JEKING LA	, 		NA I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
V 109	Continued From page	e 6		V 109			
	Disorder, Impulse Co Unspecified Anxiety D						
	Review on 11/16/21 revealed:						
	- Age: 8	ission: 7/7/21					
	 Diagnoses: PTSD, Disruptive Mood Dysregulation, ADHD-combined type, Borderline Intellectual Functioning, other development disorders, and speech/language disorder A. Examples the QP failed to ensure minimum staffing ratios. Review on 11/17/21 of the facility's Level III Operations Manual ("OpsManual") revealed: "Para Professionals (as defined by 10A NCAC 27G .0104) The minimum number of direct care staff during child or adolescent sleep hours is as follows: two direct care staff shall be present and one shall be awake for one through four children or adolescents." 						
			m				
	Report Progress Note - "On 11/12/20 redirected to discontil physical aggression to Staff separated consult ignore his peer and coresponsibilities with note that the control of the contro	O21 consumer was bein nue using verbal and owards his peer [client aumer instructed consum ontinue completing his po further problems."	#2]. er to om				
	client #2 and client #4	client #1 reported: physical altercation be					

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			CONSTRUCTION		E SURVEY PLETED
				A. BUILDING: _			_
		mhl043-039		B. WING		11	R I/ 23/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIEDDA'S	RESIDENTIAL SERVICE	ES GROUP HOME #2	21 LANEXA	A LANE			
SILIKINA S	RESIDENTIAL SERVICE		SPRING LA	AKE, NC 2839)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FILE OF THE STATE OF T		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 109	V 109 Continued From page 7			V 109			
	client #4 attacked hin - Staff #6 was when the incident occ Interview on 11/17/21 - There was a client #2 but he was in - Staff #6 was Interview on 11/18/21 - She was the facility between 4:00- arrived on 11/12/21. - Staff #8 had be late on shift as he - She was toli informed the QP that	a physical altercation in n on 11/12/21. s working that shift by hourred. I client #4 reported: a physical altercation wo not sure of when it occus working by herself. I staff #6 reported: a only staff member in the 19:30 pm when staff #8 I called to inform her her had a family emergence by staff #8 that he had he would be late.	ith urred. the e would cy.				
	the only staff membe - The physica	contact the QP about bur on duty. al altercation between curred between 7:15 pm	lient				
		2. Observation on 11/16/21 from 9:30-11:00 am revealed one staff (#5) with one client (client #1) at the facility.					
		1 staff # 5 reported: home with client #1 as I was not registered in s					
	reported:	1/16/21-11/23/21 the Qf					
		read the program rules					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			756.2516.		R
		mhl043-039	B. WING	·····	11/23/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE	
CIEDDAIC	DECIDENTIAL CEDVICE	S CROUD HOME #2 21 LANE)	XA LANE		
SIERRA S	RESIDENTIAL SERVICE	SPRING I	LAKE, NC 28390		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 109	Continued From page	8	V 109		
	requirement for up to He was awa worked by themselved He was unan herself during the inci #2 and client #4. He was awa facility on 11/16/21 wi was admitted on 11/1 for school yet. He was resp staffing schedule. He schedule herself during first shi staff were required at He fills in for He was awa	ware that staff #6 worked by dent on 11/12/21 with client re that client #1 was at the th only one staff as client #1 0/21 and was not registered onsible for developing the d staff #5 with client #1 by ft as he was unaware that 2 all times. staff when they "call out." re of the repairs needed in d that the facility was in the			
	reported: - The facility of facility schedule. - The schedul - The QP was coverage if staff "call - She was una worked alone during a B. Example the QP fa Reporting Information Refer to V367 for speelopement incident. - Two or three into the woods.	aware that facility staff any shift. iled to report in the Incident			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		` ′	CONSTRUCTION	(X3) DATE S COMPL	
				A. BOILDING.		F	·
		mhl043-039		B. WING		I	3/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIFRRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA	LANE			
OILITITA O	TRESIDENTIAL SERVICE		SPRING LA	KE, NC 2839	0		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIMENCY)	D BE	(X5) COMPLETE DATE
V 109	Continued From page 9		V 109				
	Review on 11/17/21 of No entries solient #4.	of the IRIS revealed: ubmitted for the elopen	nent of				
	Interview on 11/17/21 the Administrator Assistant reported: - The facility QP is responsible for submitting level II incident reports. - She was unaware that the report had not been submitted. Interview on 11/17/21 the QP reported: - A facility incident report was completed by staff #5. - Staff #5 documented the incident in client #4's facility Incident Report Progress Note.						
	C. Example the QP fa	ailed to ensure that staff specific needs.	f				
	Interview on 11/16/21 the Qualified Professional (QP) reported: - They admitted a client (client #1) with a history of sexually aggressive behavior on						
	training topics are pre - They have h behavior training, cris training on self injurio - He was una for the sexually aggre	ad sexually aggressive is intervention training a us behaviors. ble to provide training d	and lates				
	Review on 11/16/21 or records revealed:	of staff #5, #6, and #7	aining.				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` ′	CONSTRUCTION	(X3) DATE S COMPL	
				7. BOILDING		F	2
		mhl043-039		B. WING		1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	\$	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA SPRING LA	LANE KE, NC 2839	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	<u> </u>	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 109	with sexually aggress - Worked first Interview on 11/18/21 - They have v monthly staff meeting when they had sexual training Worked secon Interview on 11/17/21 reported: - "They haven aggressor training, but as possible." - The facility's Intervention (NCI) Tra facilitate sexually agg - There is no operedator training. Review on 11/16/21 of Minutes from January revealed:	staff #5 reported: In dealing with adolescentive behavior. In dealing with adolescentive behavior. In dealing with adolescentive behavior. It is staff #6 reported: It is a re	neir nber ant on	V 109			
V 296	27G .1704 Residential Staffing 10A NCAC 27G .1704 REQUIREMENTS (a) A qualified profess	4 MINIMUM STAFFII		V 296			
	telephone or page. A able to reach the facil times.	sional shall be available direct care staff shall be ity within 30 minutes at a mber of direct care staff on or adolescents are	;				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		SURVEY PLETED
			A. BOILDING			D
		mhl043-039	B. WING		11	R / 23/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ΓΕ, ZIP CODE		
OIEDDAI	DECIDENTIAL CEDITION	21 LAN	EXA LANE			
SIERRA	S RESIDENTIAL SERVICE	SPRING	B LAKE, NC 28390)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 296	Continued From page	e 11	V 296			
V 290	present and awake is (1) two direct of one, two, three or fou (2) three direct for five, six, seven or adolescents; and (3) four direct of nine, ten, eleven or to adolescents. (c) The minimum nur during child or adoles follows: (1) two direct of and one shall be awa children or adolescer (2) two direct of and both shall be awa children or adolescer (3) three direct of which two shall be asleep for nine, ten, of adolescents. (d) In addition to the care staff set forth in Rule, more direct car the facility based on to individual needs as s plan. (e) Each facility shall supervision of childre are away from the face	s as follows: sare staff shall be present for a children or adolescents; care staff shall be present eight children or care staff shall be present for welve children or mber of direct care staff scent sleep hours is as care staff shall be present ake for one through four ats; care staff shall be present ake for five through eight ats; and care staff shall be present awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this e staff shall be required in the child or adolescent's pecified in the treatment I be responsible for ensuring an or adolescents when they cility in accordance with the individual strengths and	V 290			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
ANDILAN	or connection	IDENTIFICATION NOWE	LIV.	A. BUILDING: _		COMIL	LILD
		mhl043-039		B. WING			₹ :3/2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	ES GROUP HOME #2	21 LANEXA SPRING LA	ALANE AKE, NC 28390	0		
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETE DATE
V 296	Continued From page	e 12		V 296			
	The findings are:	ew, observation and failed to provide the direct care staff required	1 .				
	Review on 11/16/21 of client #1's record revealed: - Date of Admission: 11/10/21 - Age: 13 - Diagnoses: Conduct Disorder, Childhood Onset Type, Attention-Deficit Hyperactivity Disorder (ADHD), Combined Type, Encounter for Mental Health Services for Perpetrator of Non-parental Child Sexual Abuse and Encounter for Mental Health Services for Victim of Child Sexual Abuse by Parent						
	Review on 11/16/21 of client #2's record revealed: - Date of Admission: 2/19/21 - Age: 13 - Diagnoses: Post Traumatic Stress Disorder (PTSD), ADHD, Unspecified Disruptive Disorder, Impulse Control Disorder and Unspecified Anxiety Disorder		ntive				
	Review on 11/16/21 of client #3's record revealed: - Date of Admission: 10/8/20 - Age: 12 - Diagnoses: Attention-deficit hyperactivity disorder combined, Oppositional defiant disorder, Autism Spectrum disorder and Learning Specific Learning Disorder with impairment in reading Review on 11/16/21 of client #4's record revealed:						
		nission: 7/7/21					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY ETED	
		mhl043-039		B. WING			R 23/2021
		111110-40-000				11/2	13/202 i
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	ES GROUP HOME #2	21 LANEXA SPRING LA	ALANE AKE, NC 28390	0		
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 296	6 Continued From page 13		V 296				
	Dysregulation, ADHD Intellectual Functionin disorders, and speec A. Observation on 11 revealed one staff (#4 at the facility. Interview on 11/16/21 - She had wo September 2021. She previously for about 2 - Was at the h	/16/21 from 9:30-11:00 5) with one client (client staff # 5 reported: rked at the home since had worked for the face	rline am #1) cility as he				
	Report Progress Note - "On 11/12/2 redirected to disconti physical aggression t Staff separated consi consumer to ignore h completing his pm re problems." - The Inciden completed and signe Interview on 11/16/21 - There was a client #2 and client #4 - Staff #6 ask de-escalating the phy - He assisted holding the hands of escorted client #4 to	021 consumer was beir nue using verbal and cowards his peer [client umer and instructed his peer and continue sponsibilities with no full transfer Progress Noted by staff #6. I client #1 reported: a physical altercation be 4 on 11/12/21. ed him to assist her in vsical altercation. in separating the client #2 while staff #6	ng #2]. rther was etween				

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MANE OF PROVIDER OR SUPPLIER MINIORATE SIERRA'S RESIDENTIAL SERVICES GROUP HOME #2 SIERRA'S RESIDENTIAL SERVICES GROUP HOME #2 21 LANEXA LANE SPRING LAKE, NC 23390 PROVIDER'S PLAN OF CORRECTION ACTION SHOULD BE GENOTICED BY FULL PREFIX LANEXA LANE SPRING LAKE, NC 23390 V 296 Continued From page 14 V 296 Continued From page 14 V 296 Interview on 11/17/21 client #2 reported: - There was a physical altercation in which client #4 attacked him on 11/12/21. - Staff #6 was working that shift by herself when the incident occurred. - Staff #6 requested that client #1 assist with de-escalating the physical altercation with client #2 but he was not sure of when it occurred. - Client #2 but he was not sure of when it occurred. - Client #2 started the altercation. - Staff #6 was working by herself. - Client #1 was asked to inform her he would be late on shift as he had a family be mergency. - She was told by staff #8 that he had informed the Qualified Professional (QP) that he would be late. - She did not contact the QP about being the only staff member on duty. - The physical altercation between 7:15 pm and 7:30 pm. - She requested that client #1 assist her by - She requested that client #1 assist her by - She requested that client #1 assist her by - She requested that client #1 assist her by - She requested that client #1 assist her by	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.			JRVEY TED				
NAME OF PROVIDER OR SUPPLIER SIERRA'S RESIDENTIAL SERVICES GROUP HOME #2 PROFICE (ACA) TO SUMMARY STATEMENT OF DEFICIENCIES PRING LAKE, NC 28390 V 296 Continued From page 14 V 296 Continued From page 14 Interview on 11/17/21 client #2 reported: - There was a physical altercation in which client #4 attacked him on 11/12/21. - Staff #6 was working that shift by herself when the incident occurred. - Client #1 pulled him away from client #4. Interview on 11/17/21 client #4 reported: - There was a physical altercation with client #2 but he was not sure of when it occurred. - Staff #6 was working by herself. - Client #1 pulled him away from client #4. Interview on 11/18/21 staff #6 reported: - Client #1 was asked to intervene by staff #6. Interview on 11/18/21. - Staff #8 had called to inform her he would be late on shift as he had a family emergency. - She was tod by staff #8 that he had informed the Qualified Professional (QP) that he would be late. - She did not contact the QP about being the only staff member on duty. - The physical altercation between client #2 and client #4 coccurred between 7:15 pm and 7:30 pm.					A. BUILDING: _			_		
SIERRA'S RESIDENTIAL SERVICES GROUP HOME #2 21 LANEXA LANE SPRING LAKE, NC 28399			mhl043-039		B. WING		1			
(X4) D SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST as PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
SPRING LAKE, NC 28390	CIEDDAIC	DECIDENTIAL CEDVICE	S CROUD HOME #2	21 LANEXA	XA LANE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 296 Continued From page 14 Interview on 11/17/21 client #2 reported: - There was a physical altercation in which client #4 attacked him on 11/12/21. - Staff #6 was working that shift by herself when the incident occurred. - Client #1 pulled him away from client #4. Interview on 11/17/21 client #4 reported: - There was a physical altercation. - Client #1 pulled him away from client #4. Interview on 11/17/21 client #4 reported: - There was a physical altercation with client #2 staff #6 was working by herself. - Client #2 but he was not sure of when it occurred. - Client #2 staff #6 was working by herself. - Client #2 staff #6 was working by herself. - Client #0.0-9:30 pm when staff #8 arrived on 11/18/21 staff #6 reported: - Staff #6 had called to inform her he would be late on shift as he had a family emergency. - She was told by staff #8 that he had informed the Qualified Professional (QP) that he would be late. - She did not contact the QP about being the only staff member on duty. - The physical altercation between client #2 and client #4 occurred between 7:15 pm and 7:30 pm.	SIERRAS	RESIDENTIAL SERVICE	:5 GROUP HOME #2	SPRING LA	KE, NC 28390	0				
Interview on 11/17/21 client #2 reported: - There was a physical altercation in which client #4 attacked him on 11/12/21. - Staff #6 was working that shift by herself when the incident occurred. - Staff #6 requested that client #1 assist with de-escalating the physical altercation. - Client #1 pulled him away from client #4. Interview on 11/17/21 client #4 reported: - There was a physical altercation with client #2 but he was not sure of when it occurred. - Client #2 started the altercation. - Staff #6 was working by herself. - Client #1 was asked to intervene by staff #6. Interview on 11/18/21 staff #6 reported: - She was the only staff member in the facility between 4:00-9:30 pm when staff #8 arrived on 11/12/21. - Staff #8 had called to inform her he would be late on shift as he had a family emergency. - She was told by staff #8 that he had informed the Qualified Professional (QP) that he would be late. - She did not contact the QP about being the only staff member on duty. - The physical altercation between client #2 and client #4 occurred between 7:15 pm and 7:30 pm.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE		
- There was a physical altercation in which client #4 attacked him on 11/12/21 Staff #6 was working that shift by herself when the incident occurred Staff #6 requested that client #1 assist with de-escalating the physical altercation Client #1 pulled him away from client #4. Interview on 11/17/21 client #4 reported: - There was a physical altercation with client #2 but he was not sure of when it occurred Client #2 started the altercation Staff #6 was working by herself Client #1 was asked to intervene by staff #6. Interview on 11/18/21 staff #6 reported: - She was the only staff member in the facility between 4:00-9:30 pm when staff #8 arrived on 11/12/21 Staff #8 had called to inform her he would be late on shift as he had a family emergency She was told by staff #8 that he had informed the Qualified Professional (QP) that he would be late She did not contact the QP about being the only staff member on duty The physical altercation between client #2 and client #4 occurred between 7:15 pm and 7:30 pm.	V 296	Continued From page 14			V 296					
"standing" near client #2 as he appeared scared. - She did not request that client #1 hold either client. - She did not use a therapeutic hold on any clients during the incident and escorted client #4 to his room.		Continued From page 14 Interview on 11/17/21 client #2 reported:								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BUILDING: _			
		mhl043-039		B. WING		11	R / /23/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			21 LANEXA	LANE			
SIERRA'S	RESIDENTIAL SERVICE	ES GROUP HOME #2	SPRING LA	KE, NC 2839	0		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 296	Continued From page 15			V 296			
	- No clients were injured in the incident.						
	client #2 and client #4 - He was una during the incident He was una involvement in the de - He was awa with client #1 He reported facility was 2 clients t - He was una 2 staff for up to four of Interview on 11/17/21 reported: - She was uni involving client #2 an - She was una alone during the incid - She was un	are of the "fight" between 4. Iware that staff #6 was aware of client #1's e-escalation of the incidence that staff #5 worked are that staff. I the staffing ratio for the to 1 staff. I ware that the facility reclients at all times. If the Administrator Assimate aware of the incident delient #4 aware that staff #6 wor	alone lent. I alone e quired istant				
	Review on 11/17/21 of the facility's Plan of Protection dated 11/17/21 submitted and written by the Administrator Assistant revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -There will always be two staff on every shift -If one staff call out the group home manager will fill the missing shift. -[The Administrator Assistant] will do random checks to assure all schedules are followed -All group home managers will turn in schedules weekly"		nts v shift unager ndom				
	"Describe your plans	to make sure the abov	re				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING: CO		
			A. BOILDING.		R
		mhl043-039	B. WING		11/23/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	XA LANE LAKE, NC 2839	0	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETE
V 296	Continued From page	e 16	V 296		
	random checks daily assure that all policie there are two staff at				
	from 8, 12 and 13 year ADHD, Autism and OPTSD, Encounter for Perpetrator of Non-paragraph Encounter for Mental of Child Sexual Abuse Borderline Intellectual disabilities. There we staff arrived on site laresulted in one staff voluming one of these in #4 engaged in a physically one of the ein the de-escalation ophysically pulled clier holding his shoulders physically took hold of #1 was significantly lared client #4, this posciients. Staff #6 was resafety of the clients in These deficient praction health, safety and we deficiency constitutes violation is not correct.	questing client #1 to assist of client #2 and #4. Client #1 of the			
V 366	27G .0603 Incident R	esponse Requirments	V 366		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		mhl043-039	B. WING		R 11/23/2021
		11111043-039			11/23/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SIEDDA'S	RESIDENTIAL SERVICE	ES GROUP HOME #3	A LANE		
JILIKIKA J	RESIDENTIAL SERVICE	SPRING L	AKE, NC 2839	0	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
V 366	Continued From page	e 17	V 366		
	40 A N.C.A.C. 07C. 0C0	2 INCIDENT			
	10A NCAC 27G .060				
	RESPONSE REQUIR				
	CATEGORY A AND E				
		3 providers shall develop and			
	implement written po				
	· ·	or III incidents. The policies			
	shall require the prov				
	()	the health and safety needs			
	of individuals involved				
		g the cause of the incident;			
		and implementing corrective			
	measures according				
	timeframes not to exc	and implementing measures			
		idents according to provider			
	-	not to exceed 45 days;			
	•	erson(s) to be responsible			
	for implementation of				
	preventive measures				
		confidentiality requirements			
		Article 2A, 10A NCAC 26B,			
	· ·	3 and 45 CFR Parts 160 and			
	164; and				
		documentation regarding			
) through (a)(6) of this Rule.			
	. •	requirements set forth in			
	` '	Rule, ICF/MR providers			
	• ,	ts as required by the federal			
	regulations in 42 CFF				
		requirements set forth in			
	• •	Rule, Category A and B			
		ICF/MR providers, shall			
		ent written policies governing			
	·	vel III incident that occurs			
	while the provider is	delivering a billable service			
	-	on the provider's premises.			
		uire the provider to respond			
	by:				
	(1) immediately	y securing the client record			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7 50.25 (6			R
		mhl043-039		B. WING		11	/23/2021
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CIEDDAIG	PERIDENTIAL REDVICE	S CROUD HOME #2	21 LANEXA	LANE			
SIERRAS	RESIDENTIAL SERVICE	5 GROUP HOME #2	SPRING LA	KE, NC 28390)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 366	(B) making a ph (C) certifying th (D) transferring review team; (2) convening a review team within 24 internal review team s who were not involved were not responsible with direct professions services at the time of review team shall confollows: (A) review the of determine the facts and make recommend occurrence of future in (B) gather othe (C) issue writte within five working da preliminary findings of LME in whose catchm located and to the LM if different; and (D) issue a final owner within three mo final report shall be se catchment area the ph LME where the client final written report shall identified by the interr include all public docu incident, and shall ma minimizing the occurr all documents needed available within three	e client record; notocopy; e copy's completeness the copy to an internal meeting of an internal hours of the incident. chall consist of individua d in the incident and wh for the client's direct ca al oversight of the clien f the incident. The internal houses of the incident opy of the client record and causes of the incident dations for minimizing the country information needed; in preliminary findings of ys of the incident. The f fact shall be sent to the ment area the provider is the where the client resident written report signed be conths of the incident. The ment to the LME in whose covider is located and to resides, if different. The fall address the issues	The als no re or t's rnal s as to nt he fact es des, y the he es or the ne or the fact the fact the ne or the fact the f	V 366			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R
		mhl043-039		B. WING		11/23/2021
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE	
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA SPRING LA	LANE KE, NC 2839(0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 366	three months to subn (3) immediately (A) the LME res area where the service Rule .0604; (B) the LME wild different; (C) the provide for maintaining and u treatment plan, if diffe provider; (D) the Departn (E) the client's applicable; and	nit the final report; and notifying the following: sponsible for the catchmeters are provided pursuant nere the client resides, if agency with responsibility pdating the client's erent from the reporting	t to	V 366		
	failed to implement we their response to incifindings are: Review on 11/16/21 revealed: - Date of Adm - Age: 13 - Diagnoses: Onset Type, Attention Disorder (ADHD), Comental Health Servic Non-parental Child S	ew and interview the facili- ritten policies governing dents as required. The of client #1's record hission: 11/10/21 Conduct Disorder, Childh h-Deficit Hyperactivity mbined Type, Encounter es for Perpetrator of exual Abuse and Encoun- vices for Victim of Child	ood · for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X			E SURVEY PLETED		
				A. BUILDING: _			
		mhl043-039		B. WING		11	R / /23/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OUEDDAIO	DECIDENTIAL CEDVICE		21 LANEXA	LANE			
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	SPRING LA	KE, NC 2839	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	e 20		V 366			
V 366	Review on 11/16/21 of a degree Adm - Age: 13 - Diagnoses: I Disorder (PTSD), ADI Disorder, Impulse Counspecified Anxiety Disorders and Service Adm - Age: 8 - Diagnoses: Indicate Disorders, and Speech A. Review on 11/17/20 redirected Impulse A. Review on 11/17/20 redirected to disconting physical aggression to Staff separated consumer to ignore his completing his pm resproblems." - The Incident completed and signed - No determining incident No corrective implemented No measure similar incidents from - No responsil	of client #2's record revisionsion: 2/19/21 Post Traumatic Stress HD, Unspecified Disrupontrol Disorder and Disorder of client #4's record dission: 7/7/21 PTSD, Disruptive Moode-combined type, Border development h/language disorder 21 of client #4's Incidered erevealed: 021 consumer was being ue using verbal and lowards his peer [client umer and instructed dispeer and continue sponsibilities with no furth the transport of the cause of the emeasures developed as developed to preven occurring. ble person identified for	otive d erline nt ng #2]. rther was ne or nt	V 366			
	measures. Interview on 11/16/21	rections and preventat client #1 reported:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		mhl043-039		B. WING		1.	R I/ 23/2021
						<u> </u>	172072021
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVIC	ES GROUP HOME #2	21 LANEXA SPRING LA	ALANE AKE, NC 2839)		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 366	client #2 and client # - Staff #6 ask de-escalating the ph - He assisted holding the hands of escorted client #4 to - Staff #6 wa the incident. Interview on 11/17/2 - There was client #4 on 11/12/21 - Client #4 at - Staff #6 wa when the incident od - Staff #6 req with de-escalating th - Client #1 pu Interview on 11/17/2 - There was client #2 but he was - Client #2 st - Staff #6 wa - Client #1 wi #6. Interview on 11/18/2 - She was the start of her shift on 1 - Staff #8 had be late on shift as he she she was to	4 on 11/12/21. ted him to assist her in ysical altercation. I in separating the client client #2 while staff #6 his room. Is working by herself due to the client #2 reported: In client #2 reported: In client #2 reported: In client #4 reported: I staff #6 reported: I staff #6 reported: I staff #6 reported:	ring ith herself esist ent #4. ith urred. y Staff y at the e would cy. id	V 366	DEFICIENCY		
	the only staff member	contact the QP about ber on duty. al altercation between curred between 7:15 pm	lient				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			SURVEY LETED	
							R
		mhl043-039		B. WING		11/	23/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	21 LANEXA SPRING LA	A LANE AKE, NC 28390	0		
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 366	Continued From page	e 22		V 366			
V 306	- She was the facility until 9:30 pm v - She request "standing" near client - She did not either client She did not clients during the incit to his room The incident - No clients w Interview on 11/23/21 - He was not only staff working dur - The incident clinical team No correctivor implemented after Interview on 11/17/21 reported: - She was unative to the was unative to the was unative to the woods.	e only staff member in the when staff #8 arrived. Led that client #1 assist he #2 as he appeared scale request that client #1 house a therapeutic hold of dent and escorted client as was very brief. Let ere injured in the incident the QP reported: Let aware that staff #6 was sing the incident. Let awas staffed with client as was staffed with client as was staffed with client as was staffed with client as ware of the incident on aware staff #6 was alone aware of any corrective as following the incident. Let 1 of facility records revealed in the facility in 40 are weeks ago, client #4 resourced to the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 resourced in the facility in 40 are weeks ago, client #4 are weeks ago,	ner by red. old on any i #4 nt. the #4's fied stant e	V 300			
	- Client #4 rar	n into the woods a secor	nd				
		tacted police to assist w	rith				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		o.	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		mhl043-039		B. WING		R 11/23	3/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE ZIP CODE	1 11/2	5/ 2 021
		2	21 LANEXA I	, ,	, 0052		
SIERRA'S	RESIDENTIAL SERVICE	S GROUP HOME #2	SPRING LAK	(E, NC 28390)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
V 366	Continued From page 23			V 366			
	were hunters in the waseason. - Police came - Client #4 ret police assistance. Interview on 11/23/21 - The facility hand all windows to ald - Interventions elopement incident in discussion with client	on site. urned in 15 minutes without the QP reported: and alarms on exterior do ert when opened. s put in place after the cluded the following: #4's clinical team, verbal client [#4] from leaving b	out				
V 367	V 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS			V 367			
	(a) Category A and E level II incidents, except the provision of billable consumer is on the provider so the provider and level II to whom the provider 90 days prior to the ir responsible for the caservices are provided becoming aware of the submitted on a for Secretary. The report in person, facsimile of means. The report strinformation:	s providers shall report all ept deaths, that occur dur le services or while the roviders premises or leve deaths involving the clien rendered any service with acident to the LME atchment area where within 72 hours of the incident. The report shall may be submitted via mar encrypted electronic hall include the following ovider contact and	ring IIII ats thin				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl043-039		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
			B. WING			
		B. WING				
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SIERRA'S	S RESIDENTIAL SERVICE	ES GROUP HOME #2	EXA LANE LAKE, NC 28390			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
V 367	Continued From page	e 24	V 367			
	(2) client identi (3) type of incid (4) description (5) status of th cause of the incident (6) other individence or responding. (b) Category A and E missing or incomplete shall submit an updar report recipients by the day whenever: (1) the provide information provided erroneous, misleadin (2) the provide required on the incide unavailable. (c) Category A and E upon request by the obtained regarding th (1) hospital reci information; (2) reports by 0 (3) the provide (d) Category A and E of all level III incident Mental Health, Devel Substance Abuse Se becoming aware of th providers shall send incidents involving a Health Service Regu becoming aware of th client death within se or restraint, the provid immediately, as requ .0300 and 10A NCAO	ification information; dent; of incident; e effort to determine the ; and duals or authorities notified B providers shall explain any e information. The provider ted report to all required he end of the next business r has reason to believe that in the report may be g or otherwise unreliable; or r obtains information ent form that was previously B providers shall submit, LME, other information he incident, including: cords including confidential other authorities; and r's response to the incident. B providers shall send a copy reports to the Division of lopmental Disabilities and ervices within 72 hours of the incident. Category A a copy of all level III client death to the Division of lation within 72 hours of the incident. In cases of even days of use of seclusion der shall report the death ired by 10A NCAC 26C				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. Boilbillo.			В
		mhl043-039	B. WING		11	R 1 /23/2021
NAME OF B	ROVIDER OR SUPPLIER	CTDEET	ADDRESS, CITY, STATE	ZIR CODE	•	
NAME OF F	NOVIDER OR SUFFLIER		EXA LANE	, ZIF CODE		
SIERRA'S	RESIDENTIAL SERVICE	ES GROUP HOME #2	G LAKE, NC 28390			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	μ-19-2-		V 367	<u></u>	· ,	
	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.					
	failed to report Level	iew and interview the facility II incidents within 72 hours of the incident affecting one				
	Review on 11/16/21 revealed: - Date of Adn - Age: 8	of client #4's record nission: 7/7/21 Post Traumatic Stress				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		mhl043-039	B. WING		R 11/23/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CIEDDAIC	DECIDENTIAL CEDVICE	21 LANE	(A LANE		
SIERRAS	RESIDENTIAL SERVICE	SPRING I	AKE, NC 2839	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 367	67 Continued From page 26		V 367		
	Dysregulation, Attention-Deficit Hyperactivity Disorder (ADHD) -combined type, Borderline Intellectual Functioning, other development disorders, and speech/language disorder Interview on 11/16/21 staff # 5 reported: - Two or three weeks ago, client #4 ran into the woods. - Client #4 returned to the facility in 40 seconds with some bricks.				
	- Client #4 ran into the woods a second				
	time - Staff #5 contacted police to assist with				
	- Staff #5 contacted police to assist with locating and returning client #4 - She was concerned for client #4 as there are hunters in the woods as it was hunting season - Police came on site Client #4 returned in 15 minutes without police assistance. Review on 11/17/21 of the Incident Reporting Information System (IRIS) revealed: - No entries submitted for the elopement of client #4.				
	reported: - The facility 0 responsible for submi - She was una	the Administrator Assistant Qualified Professional (QP) is tting level II incident reports. aware that the report had not			
	by staff #5.	dent report was completed umented the incident in client			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl043-039	B. WING		1	R I/ 23/2021
	ROVIDER OR SUPPLIER	S GROUP HOME #2	ADDRESS, CITY, STATE EXA LANE LAKE, NC 28390	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From page	27	V 736			
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	-	EMENTS				
	failed to ensure the ho	as evidenced by: n and interview, the facility ome was maintained in a tive manner. The findings				
	Observation on 11/16 pm revealed:	/21 between 11:00am-12:00				
	- Two light bul table.	bs out over dining room				
	- Two light bul room light.	bs out in over head family				
	- One light bu client #2's bedroom.	lb out in overhead light in				
	- Wood floor p #2's bedroom.	olanking popped up in client				
	- Fist size hole shared bedroom.	e in wall of client #3 and #4's				
	drawer were laying in	ont of the bottom dresser pieces in the bottom of the				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED			
mhl043-039		B. WING		R 11/23/2021				
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
SIERRA'S	SIERRA'S RESIDENTIAL SERVICES GROUP HOME #2							
			AKE, NC 2839					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE			
V 736	Continued From page	28	V 736					
	bedroom.							
	- Separated w #3 and #4's shared be	ood plank flooring in client edroom.						
	 Door knob size hole behind the bathroom door where the knob was making contact in the wall of hallway bathroom. 							
- Sink in the hallway bathroom did not drain after water faucet was turned on.								
	- Client #1's b that was separated a	edroom had wood planking nd popped up.						
	 Closet door of client #1's bedroom was cracked on both sides halfway down the door. Hall smoke alarm chirping. Paint peeling on the wall of the "game room." 							
	(QP) reported: - Division of H Construction team ha	the Qualified Professional lealth Service Regulation d conducted a survey ty was in the process of d repairs.						
	This deficiency consti and must be correcte	tutes a re-cited deficiency d within 30 days.						

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