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 11/23/2021

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 An annual and follow up survey was completed on November 23, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement	V 105		

Division of Health Service Regulation

Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBR: **MHL # 043-050**	(X2) Multiple Construction A. Building: 01 B. WING_____	(X3) DATE SURVEY COMPLETED **01/17/2022**

NAME OF PROVIDER:	STREET ADDRESS, CITY, STATE, ZIP CODE	
SIERRA'S RESIDENTIAL 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
V 000	An annual and follow up survey was completed on November 23, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents	V 000	Indicate what measures will be put in place to ***correct*** 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 ***prevent*** 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.	**01/17/2022**
\V 105	27G .0201 (A) (1-7) Governing Body Policies This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their written policies for admission 2 of 3 audited clients, (#1 & #2).	\V 105	SRS QP (Group Home Manager) will Adhere to and Follow the Agency's Written Policies regarding the Admission of SRS' Consumer(s) into its Level III Residential Treatment Facilities. SRS QP (Group Home Manager) will arrange for an Admission Assessment to be completed for "New Consumer(s) Admissions" to include Lateral Transfers within the SRS Agency. SRS Medical Records Personnel will Audit 35 % pf the Consumer's Medical Records Randomly at Least on a Quarterly Basis to ensure Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE (X6) DATE

Kristie Vanhook, MSW, LCSW Clinical Director 1/17/2022

STATE FORM 6899 FE6922 If continuation sheet 1 of 1

SIERRA'S RESIDENTIAL SERVICES, INC.
P. O. Box 665
Lillington, NC 27546

DISCHARGE SUMMARY

Client: [redacted]	Record: [redacted]	Date of Admission:	Date of Discharge: 11/10/2021

Identifying Information:
Name: [redacted]
Race: Native American
Gender: Male
Age: 9 years old
Medicaid Number: [redacted]
Birthdate: [redacted]

Reason for Admission:
Consumer is a Native American male, age 9, who presents with symptoms of posttraumatic stress, oppositional defiance, and attention-deficit hyperactivity disorder. Consumer was born in Wilmington, NC. Consumer has been in the New Hanover foster care system since 2017 (age 6) after it was suspected that consumer's mother was abusing substances. As a result of being removed from his mother's home, he has experienced trauma from separation and displays symptoms indicative of insecure attachment (i.e., difficulty regulating emotions, displays of aggression, and challenges in interacting competently with peers). Previous treatments for [redacted] have included: Intensive Alternative Family Treatment (IAFT) and Therapeutic Foster Care (TFC) through the Bair Foundation, Intensive In-Home (IIH) treatment through Coastal Horizons Center, Inc., Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), psychiatric hospitalization (May 2021), and medication management through the Wilmington Health Access for Teens (WHAT) clinic. Consumer has been prescribed the following medications: Cetirizine (10 mg), Montelukast (5 mg), Clonidine (0.2 mg-PM), Clonidine (0.1 mg-AM), Desmopressin (0.2 mg), Carbamazepine (100 mg), Citalopram (10 mg), Jornay (40 mg), Saphris (10 mg). Consumer has previously maintained placement in Intensive Alternative Family Treatment (IAFT) for nearly a year and was then stepped down to Intensive In-Home (IIH) Services. Per reports from consumer's New Hanover DSS social worker, consumer recently became physically aggressive with staff (i.e., "punching") and was subsequently involuntarily committed. Consumer continues to struggle with defying authority figures, using profanity, and making negative statements. Consumer has consistently had difficulty with managing his anger outbursts, especially when provoked by his peers. Consumer also likes to "show off" in front of his peers and can become more defiant and oppositional when encouraged or incited by them. Consumer has struggles to process his past traumas and can easily become dysregulated when he is triggered, provoked, or overwhelmed. Consumer's high risk aggressive behaviors and defiance have persisted in multiple environments which warrant more intensive monitoring and therapeutic services to ensure consumer's safety as well as the safety of others. Due to consumer's aforementioned behaviors, consumer currently meets criteria for Level III residential placement. The clinician recommends that consumer receive Level III Residential treatment that will provide him with the ongoing behavioral supports, the 24-hour monitoring and the structured environment conducive

for assisting him with further developing and maintaining the skills necessary for improving his issues of impulsivity, physical & verbal aggression, emotional dysregulation, poor social skills and decision-making skills.

Brief Summary of Treatment & Significant Findings:

Consumer is in a Level III Residential Facility.
Consumer was attending group therapy twice every week with SRS and individual therapy once every week with the carter Clinic and Medication Management with The Carter Clinic once a month. Consumer Primary Care was with Kidz Care Pediatrics.

Condition Upon Discharge Based on Person Centered Plan and Goals Set:
Goal: 1
[redacted] will interact in the group home, community and in the school setting in an age appropriate and socially acceptable manner. He will respect authority figures and will demonstrate the ability to develop positive peer relationships.

[redacted] will develop healthier relationship with others as evidenced by: Decreasing symptoms of ADHD, verbal and physical aggression, lying on others and exhibiting defiant behavior from 7 days to no more than 2 days per week over the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal #: 2
[redacted] will identify triggers to his anger outbursts. He will develop and utilize coping skills that will allow him to manage his anger without escalating to the point of verbal and physical aggression. [redacted] will also gain an understanding of empathy and how his behaviors and actions affect not only himself but those around him.

[redacted] will learn how to identify and manage his anger, bullying, lying and impulsive behavior as evidenced by being able to: communicating honestly, controlling his impulses, no bullying behavior and to follow directions 5 out of 7 days per week for the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal: # 3
[redacted] will learn coping skills to assist in alleviating symptoms of anger, decreasing anger outbursts, and learning to deal with anger in more appropriate ways as evidenced by no more than 3 reports weekly of anger outbursts weekly over the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal: # 4
[redacted] will also maintain a healthy amount of sleep and rest each night on a daily basis.

SIERRA'S RESIDENTIAL SERVICES, INC.
P. O. Box 665
Lillington, NC 27546

DISCHARGE SUMMARY

Client: [redacted]	Record: [redacted]	Date of Admission:	Date of Discharge: 11/10/2021

Goal will be met when [redacted] is able to consistently follow his bedtime schedule on time, eliminates crisis episodes to '0" occurrences and sleeps or rest quietly throughout the night without disruption on a daily basis for a consecutive period of 60 days as evidence by Self-reports, Level III Residential Staff reports.

Medications:

Cetirizine	10mg
Montelukast	5mg
Clonidine	0.2mg
Clonidine	0.1 mg
Desmopressin	0.2 mg
Carbamazepine	100 mg
Citalopram	10mg
Jornay	40mg
Saphris	10mg
Asenapine	5mg

Recommendations:
Child and Family Team met and agreed that consumer would best fit House III due to his age. The team and consumer agreed that the transition would better suit consumer needs for his age socially. Consumer and guardian (DSS) and his biological mother posed no concerns. The CFT agreed consumer will Continue with Therapy and Medication Management with the Carter Clinic. The CFT agreed that consumer will transfer his current school to Johnsonville Elementary.

Referral(s) at Termination:
None

Reason for Termination:
N/A

Final Diagnosis:

DSM Code:	Diagnosis:
F43.10 (309.81)	Posttraumatic stress disorder
F90.2 (314.01)	Attention-deficit/hyperactivity disorder; Combined presentation

Signature of Supervisor / QP: [signature] BSQP Title BSQP Date: 11-10-21

SIERRA'S RESIDENTIAL SERVICES, INC.
P. O. Box 665
Lillington, NC 27546

ADMISSION SUMMARY

Client: [redacted]	Record: [redacted]	Date of Admission: 11/10/2021	Date of Discharge:

Identifying Information:
Name: [redacted]
Race: Native American
Gender: Male
Age: 9 years old
Medicaid Number: [redacted]
Birthdate: [redacted]

Reason for Admission:
Consumer is a Native American male, age 9, who presents with symptoms of posttraumatic stress, oppositional defiance, and attention-deficit hyperactivity disorder. Consumer was born in Wilmington, NC. Consumer has been in the New Hanover foster care system since 2017 (age 6) after it was suspected that consumer's mother was abusing substances. As a result of being removed from his mother's home, he has experienced trauma from separation and displays symptoms indicative of insecure attachment (i.e., difficulty regulating emotions, displays of aggression, and challenges in interacting competently with peers). Previous treatments for [redacted] have included: Intensive Alternative Family Treatment (IAFT) and Therapeutic Foster Care (TFC) through the Bair Foundation, Intensive In-Home (IIH) treatment through Coastal Horizons Center, Inc., Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), psychiatric hospitalization (May 2021), and medication management through the Wilmington Health Access for Teens (WHAT) clinic. Consumer has been prescribed the following medications: Cetirizine (10 mg), Montelukast (5 mg), Clonidine (0.2 mg-PM), Clonidine (0.1 mg-AM), Desmopressin (0.2 mg), Carbamazepine (100 mg), Citalopram (10 mg), Jornay (40 mg), Saphris (10 mg). Consumer has previously maintained placement in Intensive Alternative Family Treatment (IAFT) for nearly a year and was then stepped down to Intensive In-Home (IIH) Services. Per reports from consumer's New Hanover DSS social worker, consumer recently became physically aggressive with staff (i.e., "punching") and was subsequently involuntarily committed. Consumer continues to struggle with defying authority figures, using profanity, and making negative statements. Consumer has consistently had difficulty with managing his anger outbursts, especially when provoked by his peers. Consumer also likes to "show off" in front of his peers and can become more defiant and oppositional when encouraged or incited by them. Consumer has struggles to process his past traumas and can easily become dysregulated when he is triggered, provoked, or overwhelmed. Consumer's high risk aggressive behaviors and defiance have persisted in multiple environments which warrant more intensive monitoring and therapeutic services to ensure consumer's safety as well as the safety of others. Due to consumer's aforementioned behaviors, consumer currently meets criteria for Level III residential placement. The clinician recommends that consumer receive Level III Residential treatment that will provide him with the ongoing behavioral supports, the 24-hour monitoring and the structured environment conducive

Client: [redacted]	Record: [redacted]	Date of Admission: 11/10/2021	Date of Discharge:

for assisting him with further developing and maintaining the skills necessary for improving his issues of impulsivity, physical & verbal aggression, emotional dysregulation, poor social skills and decision-making skills.

Brief Summary of Treatment & Significant Findings:
Consumer has transferred to House III on 11/10/21 *Child and Family Team requested.
Consumers service goals were reviewed and will continue in Level III program.
Consumer will attend group therapy twice every week with SRS and individual therapy once every week with the carter Clinic and Medication Management with The Carter Clinic once a month. Consumer Primary Care was with Kidz Care Pediatrics.

Condition Upon Discharge Based on Person Centered Plan and Goals Set:
Goal: 1
[redacted] will interact in the group home, community and in the school setting in an age appropriate and socially acceptable manner. He will respect authority figures and will demonstrate the ability to develop positive peer relationships.

[redacted] will develop healthier relationship with others as evidenced by: Decreasing symptoms of ADHD, verbal and physical aggression, lying on others and exhibiting defiant behavior from 7 days to no more than 2 days per week over the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal #: 2
[redacted] will identify triggers to his anger outbursts. He will develop and utilize coping skills that will allow him to manage his anger without escalating to the point of verbal and physical aggression. [redacted] will also gain an understanding of empathy and how his behaviors and actions affect not only himself but those around him.

[redacted] will learn how to identify and manage his anger, bullying, lying and impulsive behavior as evidenced by being able to: communicating honestly, controlling his impulses, no bullying behavior and to follow directions 5 out of 7 days per week for the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal: # 3
[redacted], will learn coping skills to assist in alleviating symptoms of anger, decreasing anger outbursts, and learning to deal with anger in more appropriate ways as evidenced by no more than 3 reports weekly of anger outbursts weekly over the next 60 days as evidence by Self-reports, Level III Residential Staff reports.

Goal: # 4
[redacted] will also maintain a healthy amount of sleep and rest each night on a daily basis.

SIERRA'S RESIDENTIAL SERVICES, INC.
P. O. Box 665
Lillington, NC 27546

DISCHARGE SUMMARY

Client: [redacted]	Record: [redacted]	Date of Admission: 11/10/2021	Date of Discharge:

Goal will be met when [redacted] is able to consistently follow his bedtime schedule on time, eliminates crisis episodes to '0" occurrences and sleeps or rest quietly throughout the night without disruption on a daily basis for a consecutive period of 60 days as evidence by Self-reports, Level III Residential Staff reports.

Medications:

Cetirizine	10mg
Montelukast	5mg
Clonidine	0.2mg
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Desmopressin	0.2 mg
Carbamazepine	100 mg
Citalopram	10mg
Jornay	40mg
Saphris	10mg
Asenapine	5mg

Recommendations:
None

Referral(s) at Termination:
None

Reason for Termination:
N/A

Final Diagnosis:

DSM Code:	Diagnosis:
F43.10 (309.81)	Posttraumatic stress disorder
F90.2 (314.01)	Attention-deficit/hyperactivity disorder; Combined presentation

Signature of Supervisor / QP: [redacted] Title QP Date: 11/10/2021

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	(X2) Multiple Construction	(X3) DATE SURVEY COMPLETED
	MHL # 043-050	A. Building: 01 B. WING_____	**01/17/2022**

NAME OF PROVIDER:	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA'S RESIDENTIAL SERVICES, INC.	**665 Lake Ridge Drive Cameron, NC 28326**

	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION)		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	27G .0209 (C) Medication Requirements This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications administered were recorded on the MAR's immediately after administration for 2 of 3 audited clients (#1 & #2).	V 118	SRS' Staff will review its medication policy and adhere to the Agency's Medication Protocol. SRS Group Home Manager (Qualified Professional) will provide SRS' Staff "A Refresher of MAR In-Service Training". SRS Group Home Manager (Qualified Professional) or Designee will review SRS's Consumer MAR(s) before leaving the Pharmacy to ensure Accuracy. In the Event of Identifying an Error, SRS' Group Home Manager or Designee will correct the MAR by notifying the Pharmacist of Error, Making the Correction by Marking through the Error, and by Handwriting the Correct Information, accompanied with the SRS' Staff's Initial. SRS Group Home Manager (Qualified Professional) will monitor the SRS' Consumer 'MAR Activities on a Daily Basis to ensure Compliance. SRS' Quality Management Team or Designee will Randomly conduct an Audit Review of SRS Consumer's MAR Activities on at Least a Quarterly Basis to ensure Compliance. Please See Attachments: • Medication Administration Class Re-Training and Sign-in Sheet	**01/17/2022**

PHARMACY INSERVICE SIGN-IN SHEET

Class Title: Medication Administration | **Meeting Date:** 1/14/2022

Instructor: Kayla Burrows, RN | **CE Hours:**

Name	Facility	Experience as a med tech?	E-Mail
Whitney Howard	H3	N/A	Whowa4@yahoo.com
Monica Spencer	H3	Med Licensed	mletrice86@gmail.com
Helena McRae	H3	N/A	lenamerce88@gmail.com
CHRIS CAMACHO	H3	N/A	CAMACHOCHRISTOPHERJ.GMAIL.COM
Angela Ware	H1	N/A	@Ware.angela@ymail.com
Brittany White	H3	N/A	
Breanna Coleman	H3	N/A	Lifewithbreprice@gmail.com
Dawn Nance VanDunk	H1	N/A	dawnlinkowich@gmail.com
Terikue	H1	N/A	
Dalena Grause	H2	N/A	Graused112@gmail.com
Linda McPhatter	H2	N/A	
Shanna Hodges	H2	N/A	Shodges.101@yahoo.com

CERTIFICATE *of* ACHIEVEMENT

THIS ACKNOWLEDGES THAT

Monica Spencer

HAS SUCCESSFULLY COMPLETED

Medication Administration

1/14/2022

x *Kayla Burrows* *RN, BSN*

SIGNED, Kayla Burrows

CAPE FEAR Rx
LONG TERM CARE

CERTIFICATE *of* ACHIEVEMENT

THIS ACKNOWLEDGES THAT

Helena McRae

HAS SUCCESSFULLY COMPLETED

Medication Administration

1/14/2022

x *Kayla Burrows* *RN, BSN*

SIGNED, Kayla Burrows

CAPE FEAR Rx
LONG TERM CARE

CERTIFICATE *of* ACHIEVEMENT

THIS ACKNOWLEDGES THAT

Breanna Coleman

HAS SUCCESSFULLY COMPLETED

Medication Administration

1/14/2022

x *Kayla Burrows* *RN, BSN*

SIGNED, Kayla Burrows

CAPE FEAR
LONG TERM CARE

Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBR: **MHL # 043-050**	(X2) Multiple Construction A. Building: 01 B. WING_____	(X3) DATE SURVEY COMPLETED **01/17/2022**
NAME OF PROVIDER: **SIERRA'S RESIDENTIAL SERVICES, INC.**		STREET ADDRESS, CITY, STATE, ZIP CODE **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
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing This Rule is not met as evidenced by: Based on observation and interviews the facility failed to provide the minimum number of direct care staff required.	V 296	Qualified Professional will assure that all shifts are covered by two Staff Members. Qualified Professional understands that there are Two Staff to One, Two. Three and Four Consumers. If there should be any Callouts, the Qualified Professional (CT) will work on that shift until a Replacement (QP, AP and/or PP) is able to relieve QP (CT) from the Shift. SRS Office Personnel or Designee will follow up with random House Audits to assure that the Qualified Professional has implemented and is following all Policies and Procedures regarding the minimum number of direct care staff required.	**01/17/2022**

Division of Health Service Regulation

Weekly Schedule

House 3 Permanent Work Schedule

Employee Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total Hours
C. Tyler, QP	8a-6p	8a-6p	8a-6P	8a-6P	8a-6P	on-call	on-call	**cover all Call-outs**
HELENA	12A-8A	12A-8A	12A-8A	12A-8A	12A-8A	off	off	**40**
MONICA	12A-8A	12A-8A	12A-8A	12A-8A	12A-8A	off	off	**40**
CHRS	2P-12A	2P-12A	2P-12A	2P-12A	off	off	off	**40**
WHITTANY	3P-12A	3P-12A	3P-12A	3P-12A	OFF	off	off	**36**
YOLANDA	off	off	off	off	3P-12A	8A-12A	8A-12A	**40**
BREANNA	off	off	off	off	4P-12A	8A-12A	8A-12A	**39**
ALEX	off	off	off	off	12A-8A	12a-8a	12a-8a	**24**
JEROME					12A-8A	12a-8a	12a-8a	**24**
BELINDA	8a-4p	8a-4p	8a-4p	8a-4p	8a4p	off	off	**40 when school is out**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBR:	(X2) Multiple Construction	(X3) DATE SURVEY COMPLETED
	MHL # 043-050	B. Building: 01 B. WING_____	**01/17/2022**

NAME OF PROVIDER:	STREET ADDRESS, CITY, STATE, ZIP CODE	
SIERRA'S RESIDENTIAL 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
V 366	27G .0603 Incident Response Requirements This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to incidents as required.	V 366	SRS' Staff will report All incidents to Qualified Professional. SRS Group Home Manager (Qualified Professional) will notify the Legal Guardian and Other Responsible Parties (Law Enforcement, Medical Personnel, etc…) Immediately upon Notification of a Level II or Level III Incident and the SRS QP (Group Home Manager) or Designated QP will Enter All Level II and Level III Incidents into the IRIS System within a 72 Hour Time Frame. SRS Group Home Manager (Qualified Professional) or Designee will provide SRS' Staff "A Refresher of Incident "Reporting In-Service Training". SRS Quality Improvement Committee will Randomly conduct an Audit Review of SRS Consumer(s) Incident Reporting Documentation/Records on at Least a Quarterly Basis to ensure Compliance. Please see Attachments: for Verification. 1. SRS Policy and Procedure 2. Incident and Incident Reporting Training and Sign-in Sheet	**01/17/2022**

Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBR: **MHL # 043-050**	(X2) Multiple Construction C. Building: 01 B. WING_____	(X3) DATE SURVEY COMPLETED **01/17/2022**
NAME OF PROVIDER: **SIERRA'S RESIDENTIAL SERVICES, INC.**		STREET ADDRESS, CITY, STATE, ZIP CODE **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	(X5) COMPLETE DATE
V 367	27G .0604 Incident Reporting Requirements This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report incidents to the Local Management Entity as required.	V 367	All Level II Incident Reports will be reported to the IRIS System within 72 Hours of the Incident. SRS' Staff will report all incidents to Qualified Professional. The Qualified Professional (CT) will notify the Legal Guardian and Other Responsible Parties (Law Enforcement, Medical Personnel, etc...) Immediately upon Notification of a Level II Incident and the QP (CT) or Designated QP will Enter All Level II AND/OR Level III Incidents into the IRIS System within a 72 Hour Time frame. Please see Attachments: for Verification. 1. SRS Policy and Procedure 2. Incident and Incident Reporting Training and Sign-in Sheet	**01/17/2022**

Sierra's Residential Services, Inc.	Policy No: SD 06 Page 1 of 8
Subject: Incident Reporting	Effective Date: 4/24/2000 Revised: 10/9/11, 5/3/12
	Scope: All Programs

Policy

An Incident Report shall be completed for any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer. These include incidents pertaining to the following critical incidents:

- Medication errors.
- Use of seclusion.
- Use of restraint.
- Incidents involving injury.
- Communicable disease.
- Infection control.
- Aggression or violence.
- Use and unauthorized possession of weapons.
- Wandering.
- Elopement.
- Vehicular accidents.
- Biohazardous accidents.
- Unauthorized use and possession of legal or illegal substances.
- Abuse.
- Neglect
- Exploitation
- Suicide and attempted suicide.
- Sexual assault.
- Overdosing
- Other sentinel events.

Definitions of levels of incidents - see prevailing DHHS Criteria for Determining Level of Response to Incidents posted on the Division's website.
http://www.ncdhhs.gov/mhddsas/providers/NCincidentresponse/index.htm

Procedure for all non-critical Level I incidents for NC Division of MH/DD/SAS funded persons served

- When a Level One incident from the above definitions occurs, staff will first attend to the health and safety needs of the individual involved.
- The person with the best and most complete knowledge shall complete the appropriate Incident Reporting Form before leaving the program at the end of a shift.
- The narrative summary shall include: what happened, actions of all involved in the incident, specific emergency intervention, a plan to

prevent future occurrences, and other relevant facts.

- The staff member's immediate or on-call supervisor will be notified by the beginning of the next business day. Staff member will submit the completed incident report to their supervisor on the morning of the following business day. The supervisor will submit a copy of the Incident Report to the Clinical Director and will complete a Note of Significance in the consumer's service record that contains a description of the event, actions taken on the behalf of the person served, and the person served's condition following the event. Incidents are not referenced in the record or filed in the record.
- The Clinical Director will determine need to contact Legally Responsible Person or Next of Kin.
- If the Clinical Director determines the need for further investigation and/or a more in-depth plan to prevent further occurrences, the Clinical Director will coordinate the investigation.
- The Clinical Director will report the results of the actions taken to prevent further occurrences upon completion. All actions to prevent further occurrences shall be in place no more than 45 days from the incident.
- The Clinical Director will maintain data for the program identifying all Level One incidents to identify and correct recurring issues.
- Documentation will be maintained describing the incidents, corrective actions taken, and preventative measures put in place.
- All Level One incidents shall be reported on the NC QM04 Incident Report Form.

Incident Response Improvement System (IRIS)- For all critical level II and III incidents the web based Incident Response Improvement System (IRIS) system will be used for completing and sending official incident reports to LME and other agencies. The following is the procedure on how this will be done.

- All incidents, regardless of level, will be reported on the latest version of the NC DMH/DD/SAS QM04 Incident Reporting Form.
- The QM04 form will be sent to the Program Director for approval.
- The Program Director will designate one or more persons in his/her program to enter the incident data into the IRIS system.
- Both the QM04 form and the IRIS printout will be sent to the Home Office to be forwarded to the Program Director.

Procedure for all <u>critical Level II incidents</u> for NC Division of MH/DD/SAS funded persons served

- When a Level Two incident from the above definitions occurs, staff will immediately attend to the health and safety needs of the individual(s) involved.
- An Incident Report shall be completed for all Level Two incidents that occur during the provision of services or while the consumer is on Agency premises. Level Two deaths shall be reported for all individuals for whom the Agency has provided any service within 90 days prior to the death.
- The report shall be made to the LME where the Agency office is located within 72 hours of becoming aware of the incident.
- The person with the best and most complete knowledge shall complete the Incident Report before leaving the program at the end of a shift.
- All sections of the Incident Report form must be completed. The narrative summary shall include: what happened, actions of all involved in the incident, specific emergency intervention, a plan to prevent future occurrences, and other relevant facts pursuant to the prevailing Incident and Death Reporting System Manual issued by the NC DHHS. A NC DHHS Form QMO4-Restrictive Intervention shall accompany the Incident and Death Report if applicable.
- The staff member's immediate or on-call supervisor will be notified at the time of the incident.
- If the Staff member cannot speak with the on-call supervisor he/she must immediately contact the next level of supervision and continue up the chain of command until they speak with a local office management team member.
- The local medical personnel may be contacted if needed. The completed Incident Report shall be given to the Clinical and Medical Director within 24 hours.
- The Clinical Director will complete a Note of Significance in the consumer's service record that contains a description of the event, actions taken on the behalf of the person served, and the person served's condition following the event. Incidents are not referenced in the record or filed in the record.
- The Clinical or Medical Director *(see italicized instruction for who has primary responsibility below)* will contact the Legally Responsible Person or Next of Kin within 24 hours of incident.
- The Incident Report will be provided to the LME in person, by fax, or by mail. The report must include the name and phone number of the Clinical and Medical Directors, consumer identification information, the type of incident, description of the incident, status of effort to determine the cause of the incident, and other individuals or authorities notified or responding. Any missing or incomplete information must be

explained.

- If at any point, if the Clinical or Medical Director or other involved staff determines that the information in the original report is erroneous, misleading or unreliable or obtains new information not available when the report was submitted to the LME, a revised report will be provided to the LME by the next business day.
- If requested by the LME, Agency will obtain and submit any additional records related to the incident including, hospital records, police reports, reports from other agencies, and a summary of Agency's response to the incident including the corrective action plan.
- If the Clinical or Medical Director determines the need for further investigation and/or a more in-depth plan to prevent further occurrences, the Clinical or Medical Director will coordinate the investigation *(see italicized instruction for who has primary responsibility below).*
- The Clinical or Medical Director *(see italicized instruction for who has primary responsibility below)* will report the results of the actions taken to prevent further occurrences upon completion. All actions to prevent further occurrences shall be in place no more than 45 days from the incident.
- The Clinical Director will maintain data for the program identifying all Level Two incidents to identify and correct recurring issues.
- Documentation will be maintained describing the incidents, corrective actions taken, and preventative measures put in place.
- *The Medical Director must review all consumer, staff, and stakeholder health and safety concerns, including individual consumer and aggregate agency incidents, seclusions, restraints, elopements, medication errors, consumer and staff injuries, and assume primary review, remediation, monitoring, and related reporting responsibilities to local, state, and national regulatory and accreditation agencies in cases involving the following:*
    - *Medication diversion;*
    - *Any allegation or suspicion of physical or sexual assault, abuse, or neglect;*
    - *Any injury or potential for injury of a consumer, or staff member;*
    - *Any death of a consumer who received services fromthe CABHA within the previous 120 calendar days;*
    - *Any sudden, unexpected, or suspicious death of a consumer's minor child or dependent adult*

Procedure for all critical Level III incidents for NC Division of MH/DD/SAS funded persons served

- When a Level Three incident from the above definitions occurs, staff will first attend to the health and safety needs of the individual(s) involved.
- The person with the best and most complete knowledge shall immediately complete the Incident Report.
- All sections of the Incident Report form must be completed. The narrative summary shall include: relevant antecedent occurrences, type of incident, actions of all involved in the incident, consequences of the incident, specific emergency intervention if needed, and other relevant facts pursuant to the prevailing Incident and Death Reporting System Manual issued by the NC DHHS. A NC DHHS Form QMO4-Restrictive Intervention shall accompany the Incident and Death Report
- The staff member's immediate or on-call supervisor will be notified at the time of the incident.
- If the Staff member cannot speak with the on-call supervisor he/she must immediately contact the Clinical or Medical Director.
- The on-call supervisor will then notify Agency Clinical and Medical Directors. The Incident Report shall be given to the Clinical and Medical Directors immediately.
- The Clinical Director will complete a Note of Significance in the consumer's service record that contains a description of the event, actions taken on the behalf of the person served, and the person served's condition following the event. Incidents are not referenced in the record or filed in the record.
- The Clinical or Medical Director *(see italicized instruction for who has primary responsibility below)* will contact the Legally Responsible Person or Next of Kin immediately.
- Level Three Incidents shall be verbally reported immediately by the Clinical or Medical Director *(see italicized instruction for who has primary responsibility below)*to the:
    - Home LME
    - Host LME
    - Provider agency responsible for the treatment plan
    - Division of MH/DD/SAS Quality Management Team
    - Authorities required by law to be notified...
    - Division of Health Services Regulation if the incident occurred in a licensed facility.

- If the Level Three Incident results in death within 7 days of a restrictive intervention, the Home and Host LME, NC Division of MH/DD/SAS and the NC Division of Facility Services (if individual was served in a licensed facility) must be notified within 72 hours of Agency's becoming aware of the death.
- All Level Three incidents occurring within 90 days of service delivery by the Agency must be reported to the LME responsible for the service area where the service was provided within 72 hours of becoming aware of the incident. The Incident Report will be provided to the LME in person, by fax, or by mail. The Incident Report must be complete with a full description of the events related to the incident. Any missing or incomplete information must be explained.
- If at any point, the Clinical or Medical Director or other involved staff determines that the information in the original report is erroneous, misleading or unreliable or obtains new information not available when the report was submitted to the LME, a revised report will be provided to the LME by the next business day.
- If requested by the LME, the Agency will obtain and submit any additional records related to the incident including, hospital records, police reports, reports from other agencies, and a summary of Agency's response to the incident including the corrective action plan.
- All Level Three incidents require the following actions:
    - The Clinical Director will immediately secure the record by making a photocopy, certifying the copy's completeness by a written statement, and provide a copy to an investigation team.
    - The original record will be sealed and locked in a secure area.
    - The Agency will establish an investigation team of at least two staff who were not directly involved in the incident nor in service delivery or supervision of the services provided to the individual.
    - The investigation process will begin within 24 hours of the incident.
    - The investigation will include a review of the copy of the individual record, a review of the Incident Report and accompanying reports, interviews with persons involved in the incident, and written employee statements, as appropriate.
    - The preliminary investigation will be completed within 5 working days of the incident and a report will be completed describing findings of fact. The report will be sent to the home and host LME's and the Medical, Clinical, and Quality

Management Director.

- A final report with all findings of fact, issues identified, pertinent public records, and recommendations for prevention of future incidents will be produced within 3 months of the incident. The final report will be signed by the CEO, Medical Director, and Clinical Director and at least one of the owners of the Agency and sent to the home and host LME's.

- A copy of all Level Three Incident Report will be sent to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within 72 hours of becoming aware of an incident related to an individual receiving MH, DD, or SA services. A copy of the Level Three Incident Report related to a death in a licensed residential program will also be sent to the Division of Health Services Regulation within 72 hours of becoming aware of the incident.
- *The Medical Director must review all consumer, staff, and stakeholder health and safety concerns, including individual consumer and aggregate agency incidents, seclusions, restraints, elopements, medication errors, consumer and staff injuries, and assume primary review, remediation, monitoring, and related reporting responsibilities to local, state, and national regulatory and accreditation agencies in cases involving the following:*
  - *Medication diversion;*
  - *Any allegation or suspicion of physical or sexual assault, abuse, or neglect;*
  - *Any injury or potential for injury of a consumer, or staff member;*
  - *Any death of a consumer who received services fromthe CABHA within the previous 120 calendar days;*
  - *Any sudden, unexpected, or suspicious death of a consumer's minor child or dependent adult*

Reports Quarterly reports will be sent to the LME on the prevailing NC DMH/DD/SAS QM 11 form by the QM Director where the local Agency office is located summarizing the following information related to MH, DD, and SA consumers:

- Medication errors
- Restrictive interventions
- Searches of an individual or his/her living area;
- Seizures of property belonging to an individual or property in the possession of an individual served
- Total number of Level **II** and Level III incidents occurring in the quarter; or a statement saying there have been no reportable incidents during the

quarter.

- The QM Director will maintain a quarterly report of all incidents involving individuals served in their office whether they are required to be reported to an LME or not. Individuals receiving services funded through other agencies/authorities involved in incidents must have the incident reported, documented in their service record, and a corrective action plan to prevent further incidents must be completed.

Retention and Disposition- The original shall be filed at the Home Office.

Trend Analysis A written analysis of all critical incidents identified is provided to the CEO.

- At least annually
- That addresses:
  - Causes
  - Trends
  - Actions for improvement
  - Results of performance improvement plans
  - Necessary education and training of personnel
  - Prevention of recurrence
  - Internal and external reporting requirements.

SIERRA'S RESIDENTIAL SERVICES INCORPORATED

Meeting Sign-In Sheet
Date: 12/29/21
Residential _____
IIHS_____

INTERNATIC

North Carolina Division of Mental Health Develop
Disabilities and Substances Abuse Services

Facilitator: Ms. Cassandra Tyler, QP
~~Incident and Incident~~ Reporting

	Print Name	Sign Name
1.	Brittany White	
2.	Breanna Coleman	Breanna Coleman
3.	AMACO Chase	
4.	Whitney Howard	Whitney Howard
5.	Helena McRae	
6.	Yolanda Vanduk	Yolanda Vanduk
7.	Monica Spencer	Monica Spencer
8.	Alex Orcy	
9.	Jerome Peoples	Jerome peoples
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		

Certificate of Completion

Awarded to

MONICA SPENCER

For Completing Incident and Incident Reporting Training

Hours: 3

Ms. Cassandra Tyler, ZP, Clinical Supervisor

Presenter/Title

December 29, 2021

Date

Identification of Criticial Incidents and Reporting Training
POST Test

Name: Monica Spencer Date: 12/20/21

1.)What is defined as an Incident?
Any happening which is non consistent with the routine operation of a facility or service of the routine care of a consumer and that is likely to lead to adverse effects upon a consumer.

2.) How many types of Incidents should be reported to the NC IRIS?
I, II & III

3) How many hours does an Agency have to report a Level II incident?
72 hours - written
immediately - verbal

4) What constitutes as a Level III incident? Name 2.
Death
physically impaired

5) Name 2 incidents that could be classified as a Level II incident.
Threatning or causing harm to others
dying of terminal illness

BONUS
1) What does IRIS mean?
Incident Reporting and Improvement Services

Certificate of Completion

Awarded to

HELENA MCRAE

For Completing Incident and Incident Reporting Training

Hours: 3

Ms. Cassandra Tyler, ZP, Clinical Supervisor

Presenter/Title

December 29, 2021

Date

Identification of Criticial Incidents and Reporting Training
POST Test

Name: Helena McRae Date: 12/29/21

1.)What is defined as an Incident?

Any thing happening that's non Consistent and the routine Operecation of the facility, Service, the routine Care for the consumer that is to lead to adverse.

2.) How many types of Incidents should be reported to the NC IRIS?

3) How many hours does an Agency have to report a Level II incident?

- Immediately at 72 hrs.

Verbal written

4) What constitutes as a Level III incident? Name 2.

- Physically impired
- Death

5) Name 2 incidents that could be classified as a Level II incident.

- Theatning or causing harm to others
- Dying of teminal illness

BONUS

1) What does IRIS mean?

- Incident reporting and improvement Services.

Certificate of Completion

Awarded to

BREANNA COLEMAN

For Completing Incident and Incident Reporting Training

Hours: 3

Ms. Cassandra Tyler, ZP, Clinical Supervisor

Presenter/Title

December 29, 2021

Date

Identification of Criticial Incidents and Reporting Training
POST Test

Name: Breanna Coleman Date: 12.29.21

1.)What is defined as an Incident?
anything that happens that is not a part of the regular routine of the facility, service or routine care of the consumer.

2.) How many types of Incidents should be reported to the NC IRIS?
level 1, level 2, level 3.

3) How many hours does an Agency have to report a Level II incident?
Verbally - immediately / written report 72 hours.

4) What constitutes as a Level III incident? Name 2.
consumer dying due to incident.
consumer becoming physically impaired due to incident.

5) Name 2 incidents that could be classified as a Level II incident.
consumer dying from terminal illness.
a consumer threatning / causing harm to others due to their behavior.

BONUS
1) What does IRIS mean?
Incident response improvement ~~systems.~~

Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATIONNUMBR: **MHL # 043-050**	(X2) Multiple Construction D. Building: 01 B. WING_____	(X3) DATE SURVEY COMPLETED **01/17/2022**
NAME OF PROVIDER: **SIERRA'S RESIDENTIAL SERVICES, INC.**		STREET ADDRESS, CITY, STATE, ZIP CODE **665 Lake Ridge Drive Cameron, NC 28326**	

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IN FORMATION)		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE		(X5) COMPLETE DATE
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 were maintained in a safe, clean, attractive and orderly manner.	V 736	The repairs regarding the aforementioned were completed by SRS' Maintenance Person on 12-2-2021. All Maintenance Orders will be immediately turned into SRS' Office and will be completed within 72 Hours upon the Office receiving the Work Order. Group Home Manager. (QP) Qualified Professional or Designated Staff will conduct Safety Checks on a Daily Basis to ensure Compliance. SRS' Personnel or Designee will provide Ongoing Monitoring of the Level III Residential Facility on a Random and Quarterly Basis to ensure Compliance Please see Attachments of repairs for Verification. 1. Photos of Repairs	**01/172022**