Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0411089 B. WING 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2008 CHATWICK DRIVE **CHATWICK HOME** GREENSBORO, NC 27407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on July 27, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. V 112 27G .0205 (C-D) V 112 Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE **PLAN** (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least RECEIVED annually in consultation with the client or legally responsible person or both; AUG 2 1 2023 (5) basis for evaluation or assessment of outcome achievement; and **DHSR-MH Licensure Sect** (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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If continuation sheet 1 of 18

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: 07/27/2023 MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE **CHATWICK HOME** GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 112 V 112 Continued From page 1 8/17/23 QP will updated ISP on 8/17/23 and has created a calendar to ensure that ISP is updated annually. QP will monitor monthly to prevent oversight. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure treatment plans were updated annually affecting 1 of 3 audited clients (#1). The findings are: Review on 7/27/23 of client #1's record revealed: -An admission date of 11/18/13 -Diagnoses of Severe Intellectual Disability, Glaucoma and Hypertension -An admission assessment dated 11/18/13 noted "requires habilitation and personal care to increase independence in self-help and activities of daily living, needs assistance with increasing communication and social involvement, needs assistance to maintain living in the home, needs assistance with financial needs, is social, good verbal receptive skills, likes money and is independent in some areas, his sister is his guardian, and he lives with his 3 brothers, and requires 24 hour supervision." -A treatment plan dated 2/1/21 noted "will become independent at home and in the community, with no more than 2 verbal prompts, will measure the appropriate amount of washing powder and Clorox (when needed) for 6 consecutive months, with no mor than 3 verbal prompts, will make his

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bed for 6 consecutive months, with no more than 2 verbal prompts, will make his lunch for the following day, with no more than 4 verbal prompts, will dust his furniture in his bedroom, with no more than 3 verbal prompts, will inform

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0411089 B. WING 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2008 CHATWICK DRIVE **CHATWICK HOME** GREENSBORO, NC 27407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 112 | Continued From page 2 V 112 staff of the numbers of pills he take for medical health, will brush his teeth daily with no more than 3 verbal prompts, will place his dirty clothes in the clothes hamper each night, will fold his clothing in his dresser drawers, will wash and dry his hands when coming in from yardwork with 80% accuracy, will pick out his clothes for the next day that will be appropriate for the weather, will wipe after using the bathroom daily, will, once a week, follow the steps of making a purchase, will walk three afternoons a week for 15 minutes, will receive personal care services to complete activities of daily living and monitor for health and safety, will spell his name with no more than 3 verbal prompts, will wipe toothpaste off the rim of his trash can after brushing his teeth, and will mop the kitchen floor once a week." -Client #1's treatment plan was not updated Interview on 7/27/23 with the Qualified Professional/Chief Executive Officer/Licensee revealed: -Was acting as the Qualified Professional (QP) for the facility as the Former QP left -Had not updated client #1's treatment plan -Would update client #1's treatment plan in the next 2 weeks. V 114 27G .0207 Emergency Plans and Supplies V 114 7/27/23 QP met with group home manager to ensure that staff 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES complete emergency drills (a) A written fire plan for each facility and monthly. QP will monitor area-wide disaster plan shall be developed and monthly to ensure drills are shall be approved by the appropriate local completed within the (b) The plan shall be made available to all staff regulations time frame. and evacuation procedures and routes shall be

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posted in the facility.

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 07/27/2023 B. WING MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE CHATWICK HOME GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 114 Continued From page 3 V 114 (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to ensure fire and disaster drills were conducted once per shift per quarter. The findings are: Review on 7/27/23 of the facility's fire and disaster drills, from July 2022 to July 2023, revealed: -7/16/22 7pm a fire drill was conducted -7/17/22 2pm an earthquake drill was conducted -7/21/22 2:15pm a fire drill was conducted -7/31/22 1pm a bomb threat was conducted -8/23/22 6am a fire drill was conducted -8/23/22 4:45pm hurricane -9/25/22 7:15pm an earthquake drill was conducted -9/24/22 6:35pm a fire drill was conducted -12/5/22 6:17pm a fire drill was conducted -1/11/23 2:30pm a fire drill was conducted -1/27/23 9am a tornado drill was conducted -2/6/23 4pm a tornado drill was conducted -2/9/23 6am a fire drill was conducted

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-3/2/23 6:30am a fire drill was conducted -3/12/23 11:30am a fire drill was conducted -4/29/23 9pm a fire drill was conducted -5/10/23 4pm a tornado drill was conducted -6/10/23 7pm a fire drill was conducted -6/24/23 8pm a hurricane drill was conducted -7/3/23 7am a fire drill was conducted

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ŀ			GREEN	SBORO, NC 274	107		
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r	V 114	1 Continued Face					
l	V 115	Continued From page	9 4	V 114			
		-7/19/23 2pm a tornac	do drill was conducted				
			7/23 of the fire and disaster				
		drills revealed:					
		the months of October	Ils were conducted during				
		the months of October December 2023	r, November, and				
			conducted during the month				
		of April 2023					
		-No fire drill was condu	ucted during the month of				
		May 2023					
		-No third shift fire and					
		conducted in the mont	hs of July and September				
		2023					
		-No third shift fire and disaster drills were conducted in the months of January and June					
		2023	ns of January and June				
		2020					
		Interview on 7/27/23 at	9.44am with staff #1				
		revealed:	or ram war stan #1				
		-Had conducted fire an	d disaster drills on her shift				
		-"We do the drills every	other month. There's a	-			
		schedule that we follow	/."				
		-Was not sure if drills h	ad been conducted on				
		third shift					
		Interview on 7/27/23 wi	th the Overlifted				
		Professional/Chief Exec					
		revealed:	oduve Omcer/Licensee				
			s: 6:30am to 2:30nm (first)				
		-The facility had 3 shifts: 6:30am to 2:30pm (first), 2:30pm to 10:30pm (second) and 10:30pm to					
		6:30am (third)					
		-Fire and Disaster drills	were to be conducted				
		every month and rotated	d on each shift.				
		-Was not sure why drills	were not being				
		conducted per the Agen	cy's policy				
		G.S. 131E-256 (D2) HC	PR - Prior Employment	V 131			1
		Verification					1
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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: AND PLAN OF CORRECTION 07/27/2023 B. WING MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE CHATWICK HOME GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 131 7/27/23 V 131 Continued From page 5 This rule has been addressed G.S. §131E-256 HEALTH CARE PERSONNEL with office administrator who REGISTRY (d2) Before hiring health care personnel into a completes all background health care facility or service, every employer at a checks for new staff. QP/ health care facility shall access the Health Care owner will ensure that Personnel Registry and shall note each incident personnel file is complete of access in the appropriate business files. prior to employment. QP will monitor upon each rehire to ensure checks are completed prior to hire. This Rule is not met as evidenced by: Based on record reviews and interview, the facility staff failed to access the HCPR registry prior to hire for 1 of 3 audited staff (#2). The findings are: Review on 7/27/23 of staff #2's record revealed: -A hire date of 12/7/21 -The HCPR was accessed on 12/8/21 Interview on 7/27/23 with the Qualified Professional/Chief Executive Officer/Licensee -The office manager was not here today (7/27/23) -"She is responsible for that (accessing the HCPR registry prior to hire for staff)." V 536 V 536 27E .0107 Client Rights - Training on Alt to Rest. Int. TRAINING ON 10A NCAC 27E .0107 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

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(a) Facilities shall implement policies and

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STATEMENT OF DEFICIENCIES				
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536 Continued From page 6		V 536		
practices that emphasize the to restrictive interventions.  (b) Prior to providing service disabilities, staff including seemployees, students or voludemonstrate competence by completing training in commother strategies for creating which the likelihood of immir or injury to a person with disproperty damage is prevente (c) Provider agencies shall based on state competencie compliance and demonstrate gathered.  (d) The training shall be cominclude measurable learning measurable testing (written a behavior) on those objective methods to determine passir course.  (e) Formal refresher training by each service provider per annually).  (f) Content of the training the provider wishes to employ method to determine passir course.  (g) Staff shall demonstrate of following core areas:  (1) knowledge and und people being served;  (2) recognizing and into behavior;  (3) recognizing the effect external stressors that may a disabilities;  (4) strategies for building relationships with persons with the stream of the provider of the provid	es to people with ervice providers, inteers, shall y successfully inunication skills and an environment in ment danger of abuse abilities or others or ed. establish training is, monitor for internal e they acted on data in petency-based, objectives, and by observation of is and measurable ing or failing the in must be completed iodically (minimum at the service ust be approved by oursuant to it is a petency in the internal and internal and infect people with in ing positive	V 536		

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/27/2023 MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE CHATWICK HOME GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 7 V 536 recognizing cultural, environmental and organizational factors that may affect people with disabilities; recognizing the importance of and assisting in the person's involvement in making decisions about their life; skills in assessing individual risk for (7)escalating behavior; communication strategies for defusing and de-escalating potentially dangerous behavior; and positive behavioral supports (providing (9)means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. Documentation shall include: (1) who participated in the training and the (A) outcomes (pass/fail); when and where they attended; and (B) (C) instructor's name; The Division of MH/DD/SAS may (2)review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. The training shall be competency-based, include measurable learning objectives, measurable testing (written and by

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observation of behavior) on those objectives and measurable methods to determine passing or

PRINTED: 07/28/2023 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0411089 B. WING 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2008 CHATWICK DRIVE **CHATWICK HOME** GREENSBORO, NC 27407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 536 Continued From page 8 V 536 failing the course. (4)The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. Acceptable instructor training programs (5)shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6)Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8)Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1)Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2)The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation

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(2)

requirements as a trainer.

the course which is being coached.

Coaches shall teach at least three times

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: AND PLAN OF CORRECTION 07/27/2023 B. WING MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE CHATWICK HOME GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 9 V 536 Coaches shall demonstrate (3)competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. Aug 17 All 3 staff will be trained in alternative to restrictive intervention. Staff is now This Rule is not met as evidenced by: Based on record reviews and interview, the responsible for getting their facility failed to ensure 3 of 3 audited staff (staff training in the month of their #1, staff #2 and the Qualified Professional/Chief Executive Officer/Licensee (QP/CEO/L)) had birthday. A checklist has updated annual training in Alternatives to been created to ensure Restrictive Interventions. The findings are: trainings are complete on its due date. QP will Review on 7/27/23 of staff #1's record revealed: monitor monthly to ensure -A hire date of 10/16/20 -Training in Alternatives to Restrictive trainings are completed Interventions expired on 5/18/23 before it expires. -No documentation of updated annual training in Alternatives to Restrictive Interventions Review on 7/27/23 of staff #2's record revealed: -A hire date of 12/7/21 -Training in Alternatives to Restrictive Interventions expired on 5/18/23 -No documentation of updated annual training in Alternatives to Restrictive Interventions Review on 7/27/23 of the QP/CEO/L's record revealed: -A hire date of 3/15/11 -Training in Alternatives to Restrictive

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	Interventions expired of No documentation of Alternatives to Restrict Interview on 7/27/23 will aware staff # Alternatives to Restrict expired.  -"I knew my training hamy mind."  27E .0108 Client Right ITO  10A NCAC 27E .0108 SECLUSION, PHYSIC. ISOLATION TIME-OUT (a) Seclusion, physical time-out may be employbeen trained and have competence in the properto these procedures. Firstaff authorized to employer procedures are retrained competence at least and (b) Prior to providing directly disabilities whose treatmined providers, employer includes restrictive interservice providers in the pro	updated annual training in tive Interventions  with the QP/CEO/L revealed: If and staff #2's training in tive Interventions had  ad expired. It just slipped  s - Training in Sec Rest &  TRAINING IN AL RESTRAINT AND  restraint and isolation yed only by staff who have demonstrated for use of and alternatives acilities shall ensure that oy and terminate these d and have demonstrated in the interventions, staff including oyees, students or the training in the use of the training	V 536	All 3 staff will be trained in clients rights-seclusion, physical restraints and isolation time-out. Staff is n responsible for getting their training in the month of their birthday. A checklist has been created to ensure trainings are complete on its due date QP will monitor monthly to ensure trainings are completed prior to expiration date.	en	Aug 17

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: AND PLAN OF CORRECTION 07/27/2023 B. WING MHL0411089 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2008 CHATWICK DRIVE CHATWICK HOME GREENSBORO, NC 27407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 537 Continued From page 11 V 537 include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: refresher information on alternatives to (1) the use of restrictive interventions; guidelines on when to intervene (understanding imminent danger to self and others); emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); strategies for the safe implementation (4) of restrictive interventions; the use of emergency safety (5)interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; prohibited procedures; (6)debriefing strategies, including their (7) importance and purpose; and documentation methods/procedures. (8)(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

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(1)

Documentation shall include:

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course;

(C) (D)

(7)

evaluation of trainee performance; and

Trainers shall be retrained at least annually and demonstrate competence in the use

documentation procedures.

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CHATWIC	K HOME		SBORO, NC 27407		
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V 537					
	of seclusion, physica	al restraint and isolation			
	time-out, as specified	d in Paragraph (a) of this			
	Rule.	u. L			
		nall be currently trained in			
	CPR.	hall have coached experience			
	(9) Trainers st	of restrictive interventions at			
	least two times with	a positive review by the			
	coach.				
	(10) Trainers s	hall teach a program on the			
	use of restrictive inte	erventions at least once			
	annually.				
	(11) Trainers s	hall complete a refresher			
	instructor training at	t least every two years.			
	(k) Service provide	rs snall maintain litial and refresher instructor			
1	training for at least				
	(1) Document	tation shall include:			
	(A) who partic	cipated in the training and the			
	outcome (pass/fail)				
	(B) when and	d where they attended; and			
	(C) instructor				
	(2) The Divis	ion of MH/DD/SAS may			
	review/request this	documentation at any time.			
	(I) Qualifications of	chall most all preparation			
	(1) Coaches requirements as a	shall meet all preparation			
	(2) Coaches	shall teach at least three			
	times the course w	which is being coached.			
	(3) Coaches	shall demonstrate			
competence by completion of coaching or train-the-trainer instruction.  (m) Documentation shall be the same preparation as for trainers.					
1					

Division of Health Service Regulation STATE FORM

STATEMEN	T OF DEFICIENCIES	T				
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 2 2	CONSTRUCTION		TE SURVEY
			A. BUILDING:		COI	MPLETED
		MHL0411089	B. WING	4	0	7/27/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
CHATWIC	CK HOME		ATWICK DRIVE			
			SBORO, NC 27407			
(X4) ID			ID	PROVIDER'S PLAN OF	CORRECTION	OVE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT	ION SHOULD BE	(X5) COMPLETE
			IAG	CROSS-REFERENCED TO T DEFICIENC		DATE
V 537	Continued From page	e 14	V 537			
	p=9		V 337			
	This Pula is not mot	oo oyidaaaad buu				
	This Rule is not met	as evidenced by: ews and interview, the				
	facility failed to ensure	e 3 of 3 audited staff (staff				
	#1, staff #2 and the C	Qualified Professional/Chief				
	Executive Officer/Lice	ensee (QP/CEO/L)) had				
	updated annual training	ng in Seclusion, Physical				
		on Time-Out. The findings				
	are:					
	Review on 7/27/23 of	staff #1's record revealed:		×		
	A hire date of 10/16/20					
	-Training in Seclusion	, Physical Restraints and				
	Isolation Time-Out exp	oired on 5/18/23				
	-No documented upda	ited annual training in				
	Seclusion, Physical Ro	estraint, and Isolation				
	Time-Out					
	Review on 7/27/23 of s	staff #2's record revealed:				
	-A hire date of 12/7/21	otali 72 0 100014 10 Vealed.				
	-Training in Seclusion,	Physical Restraints and				
	Isolation Time-Out exp	pired on 5/18/23-No				
	documented updated a	annual training in				
	Seclusion, Physical Re Time-Out	estraint, and Isolation				
	rime-Out					
	Review on 7/27/23 of t	he QP/CFQ/L's record				
	revealed:	1.020,20,000,0				
	-A hire date of 3/15/11					
r  -	Training in Seclusion,	Physical Restraints and				
	Isolation Time-Out exp	ired on 3/15/23				
-	-No documented updat Seclusion, Physical Re	ed annual training in				
-	Time-Out	straint, and isolation				
	umai Tab					
1	nterview on 7/27/23 wi	th the QP/CEO/L revealed:				
<del>-</del>	Was not aware staff #1	and staff #2's training in				
5	Seclusion, Physical Res	straint, and Isolation				1
	Fime-Out					
-	i knew my training had	d expired. It just slipped				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL0411089	B. WING	07/27/2023
		ARREST CITY STATE ZIR CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## CHATWICK HOME

2008 CHATWICK DRIVE GREENSBORO, NC 27407

PREFIX (EACH TAG REGU	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION)  From page 15	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	From page 15	1	DEFICIENCY)	
my mind."		V 537		
10A NCAC EXTERIOF (c) Each fa maintained manner an odor.  This Rule Based on was not m attractive i  Observation revealed: -Both of th facility's fr -In the face 6-inch are -The clien was runni -The clien burned ou -The wall between i -Client #1 that was -Client #1 missing -The clier ring arou -The ceilit burned-ou -The ceilit burned-ou -The ceilit control in the face in the face of the	C 27G .0303 LOCATION AND OR REQUIREMENTS facility and its grounds shall be ad in a safe, clean, attractive and orderly and shall be kept free from offensive  e is not met as evidenced by: nobservations and interviews, the facility maintained in a safe, clean, and e manner. The findings are:  tions on 7/27/23 at 8:56am of the facility the metal handrails that led to the front door were loose acility's entryway, there was a 6 inch by rea that had water damage ants' bathroom located on the upper floor ning ents' bathroom vanity had a light bulb	V 736	Some repairs has been completed; others are to be completed by the identified date:  • outdoor metal rails to be repaired by September 20, 2023.  • Ceiling to be repaired by Sep 20, 2023  • Toilet was repaired on August 2, 2023  • Bathroom light bulb above vanity repaired August 2, 2023  • painting in bathroom to be ccompleted by September 1, 2023  • Agency will purchase a new dresser by Sept. 1, 2023  • Tub is clean; however, ring is from the porcelain wearing down  • Ceiling fan light bulb replaced on August 2, 2023  • handrail will be painted by Sept 1, 2023.	Sep 20  Sep 20  aug 2  aug 2  sept 1  na  aug 2  sept 1

STATEMENT OF DEFICIENCIES (X1) F		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	Toyou Date	
		OF CORRECTION	IDENTIFICATION NUMBER:				
	MHL0411089  AME OF PROVIDER OR SUPPLIER  HATWICK HOME  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 16  Interview on 7/27/23 with staff #1 revealed: -"The clients' legal guardian had been contacted about the leak in the ceiling. It was fixed and then						
-			MHL0411089	B. WING		07/	27/2022
NA	ME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1 011	2112023
Cł	IATWIC	CK HOME	DEPTICIONICIS CORRECTION  (X1) PROVIDER/SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2008 CHATWICK DRIVE  STREET ADDRESS, CITY, STATE, ZIP CODE  2008 CHATWICK DRIVE  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER AT THE CONSTRUCTION (RECOLATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER AT THE CONSTRUCTION (RECOLATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER AT THE CONSTRUCTION (RECOLATORY OR LSC IDENTIFYING INFORMATION)  PROVIDER ALL OF COMBECTIVE ACTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ONTE  ONTE  ONTE  ONTE  The clients' legal guardian had been contacted bout the leaking the ceiling, it was fixed and then arread leaking again last month (June 2023)."  The clients' legal guardian had been contacted and the ceiling. It was fixed and then arread leaking again last month (June 2023)."  The railings. We are in the process of getting at fixed. We had the driveway repaired earlier, ee clients' Legal Guardian (LG) owns the house, tween her and fixed Quardian (LG) owns the house. The colling it only leaks when it rains. We ta towel on the floor. [The QPICEOU.]) is aware to the ceiling, it only leaks when it rains. We ta towel on the floor. [The QPICEOU.]) is aware to the leaking I would say about a ar, if that. We change the lightbulbs alotThe s are hard on the toiler. The toilet gets aged up because they put too much tissue in toilet sometimes  Toriew on 7/27/23 with the Qualified fessional/Chief Executive Officer/Licensee paled: sis aware there were some repaired needed to facility the clients' all had the same Legal Guardian. It eight is sister, and she owns the home. She is re the ceiling had a leak in the hallway. If she transk the repease, we will put your				
				BORO, NC 274	407		
	REFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (36 Continued From page 16		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
	to fa	Interview on 7/27/23 w -"The clients' legal gua about the leak in the co started leaking again la  Interview on 7/27/23 w -Was aware there were facility -"The railings. We are it that fixed. We had the of The clients' Legal Guar Between her and [the O Professional/Chief Exec (QP/CEO/L)], it will be t leak in the ceiling, it onl put a towel on the floor. of it. Her brother who we but he got sick, and eve holdit has been leaking year. if that. We change guys are hard on the toi clogged up because the the toilet sometimes"  Interview on 7/27/23 with Professional/Chief Exec revealed: -Was aware there were s he facility "The clients' all had the s their sister, and she over aware the ceiling had a lie can't make the repairs, we protest and do it." "We have a consumer the	with staff #1 revealed: ardian had been contacted eiling. It was fixed and then ast month (June 2023)."  with staff #2 revealed: a repairs needed in the  and the process of getting driveway repaired earlier. Ardian (LG) owns the house. Qualified cutive Officer/Licensee taken care of it. With the y leaks when it rains. We [The QP/CEO/L) is aware as supposed to repair it, trything has been put on and I would say about a the lightbulbs a lotThe let. The toilet gets by put too much tissue in  the Qualified utive Officer/Licensee  some repaired needed to  same Legal Guardian. It was the home. She is eak in the hallway. If she we will put up our  nat stuff's things in the erbecause it (the the plumber said the han new homeswe	V 736	QP will have group hom manager complete quark health and safety checks ensure cleanliness and s	terly s to	

Division of Health Service Regulation  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED		
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:				
		MHL0411089	B. WING 07/27/2023				
	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
			HATWICK DRIVE				
CHATWICK HOME GREET			ISBORO, NC 27407	THE STATE OF	DDECTION	(X5)	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MOST BE TRESEDED BY			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE	

Division of Health Service Regulation STATE FORM