

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/14/2023
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NAME OF PROVIDER OR SUPPLIER CHATHAM COUNTY GROUP HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 813 TANGLEWOOD DRIVE SILER CITY, NC 27344
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(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on November 14, 2023. The complaint was unsubstantiated (intake #NC00207615). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000	<p style="text-align: center;">RECEIVED FEB 7 2024 DHSR-MH Licensure Sect</p>	

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

Maria J. Mason

TITLE

Executive Director

(X6) DATE

11/30/23

STATE FORM

6899

BDJF11

If continuation sheet 1 of 1