STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 complaint survey was completed on 1/21/25. The complaint was unsubstantiated (intake #NC00226027). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is	V 132	RECEIVED FEB 10 2025 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria J. Mason, Executive Director

TITLE

(X6) DATE: 1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 132	Continued From page 1 providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are: Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed: -"On 1/4/25 [client #1] told [staff #2] that [staff #1] hit her, threw her to the ground & broke her glasses. [Client #1] showed [staff #2] the break in the glasses frame and where she was hit on her side. She showed me 2 scratches on her arms where she said [staff #1] scratched her, pulling off her shirt." Review on 1/21/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against staff #1 related to the 1/3/25 incident with client #1. Interview on 1/21/25 with the Case Manager revealed: -She was aware of the 1/3/25 incident with client #1 and staff #1. -She didn't know client #1 alleged staff #1 hit her and broke her glasses during that incident.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 132	Continued From page 2 -She didn't report the incident to Health Care Personnel Registry (HCPR). -"I could not do something I did not know about." Interviews on 1/16/25 and 1/21/25 with the Executive Director/Qualified Professional revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #2 called her on 1/4/25 and reported client #1 told her that staff #1 hit her and broke her glasses during that incident on 1/3/25. -She did investigate the incident once it came to her attention. -She did not report the allegation of abuse with client #1 alleging staff #1 hit her and broke her glasses to HCPR. -She confirmed the agency failed to report an allegation of abuse to HCPR within five working days.	V 132	The Executive Director will report all allegations as required regardless of nature to DSS. Case Manager will report to IRIS as required for all allegations in the required time. All staff will complete the required Incident Report within the allotted time and submit to Executive Director.	1/21/25
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318	Executive Director will report all allegations to HCRP within 24 hours of any allegation.	1/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 318	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations of abuse affecting one of four audited staff (#1). The findings are: Review on 1/17/25 of staff #1's personnel record revealed: -Date of hire was 9/14/22. -Hired as a Support Staff. Review on 1/17/25 of client #1's record revealed: -Admission date of 4/3/23. -Diagnoses of Moderate Intellectual Disability, Overweight and Acanthosis Nigricans. Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed: -"On 1/4/25 [client #1] told [staff #2] that [staff #1] hit her, threw her to the ground & broke her glasses. [Client #1] showed [staff #2] the break in the glasses frame and where she was hit on her side. She showed me 2 scratches on her arms where she said [staff #1] scratched her, pulling off her shirt." Review on 1/21/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against staff #1 related to the 1/3/25 incident with client	V 318	All allegations will be reported to HCPR in the required allotted of time. The Case Manager and/or Executive Director will perform the report.	1/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 318	Continued From page 4 #1. -The Health Care Personnel Registry (HCPR) section was not informed of the allegation of abuse within 24 hours. Interview on 1/21/25 with the Case Manager revealed: -She was aware of the 1/3/25 incident with client #1 and staff #1. -She didn't know client #1 alleged staff #1 hit her and broke her glasses during that incident. -She didn't report the incident to HCPR within 24 hours of becoming aware of the incident. -"I could not do something I did not know about." Interviews on 1/16/25 and 1/21/25 with the Executive Director/Qualified Professional revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #2 called her on 1/4/25 and reported client #1 told her that staff #1 hit her and broke her glasses during that incident on 1/3/25. -She did investigate the incident once it came to her attention. -She did not report the allegation of abuse to HCPR within 24 hours of becoming aware of the incident.	V 318		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 366	Continued From page 5 response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 366	Continued From page 6 review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 366	Continued From page 7 (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement a policy governing their response to a Level III incident as required. The findings are: Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed: -"On 1/4/25 [client #1] told [staff #2] that [staff #1] hit her, threw her to the ground & broke her glasses. [Client #1] showed [staff #2] the break in the glasses frame and where she was hit on her side. She showed me 2 scratches on her arms where she said [staff #1] scratched her, pulling off her shirt." Review on 1/21/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against staff #1 related to the 1/3/25 incident with client #1.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 366	Continued From page 8 -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 1/21/25 with the Case Manager revealed: -She was aware of the 1/3/25 incident with client #1 and staff #1. -She didn't know client #1 alleged staff #1 hit her and broke her glasses during that incident. -She didn't put the 1/3/25 incident with client #1 and staff #1 into IRIS. -"I could not do something I did not know about." Interviews on 1/16/25 and 1/21/25 with the Executive Director/Qualified Professional revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #2 called her on 1/4/25 and reported client #1 told her that staff #1 hit her and broke her glasses during that incident on 1/3/25. -She did investigate the incident once it came to her attention. -She did not put the incident into IRIS once the abuse allegation came to her attention. -The Case Manager was responsible for putting incidents into IRIS. -She confirmed the facility failed to implement a policy governing their response to a Level III incident as required.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 367		V 367		
	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 367	Continued From page 10 (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 367	Continued From page 11 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed: -"On 1/4/25 [client #1] told [staff #2] that [staff #1] hit her, threw her to the ground & broke her glasses. [Client #1] showed [staff #2] the break in the glasses frame and where she was hit on her side. She showed me 2 scratches on her arms where she said [staff #1] scratched her, pulling off her shirt." Review on 1/21/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against staff #1 related to the 1/3/25 incident with client #1. Interview on 1/21/25 with the Case Manager revealed: -She was aware of the 1/3/25 incident with client #1 and staff #1.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 367	Continued From page 12 -She didn't know client #1 alleged staff #1 hit her and broke her glasses during that incident. -She didn't put the 1/3/25 incident with client #1 and staff #1 into IRIS. -"I could not do something I did not know about." -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interviews on 1/16/25 and 1/21/25 with the Executive Director/Qualified Professional revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #2 called her on 1/4/25 and reported client #1 told her that staff #1 hit her and broke her glasses during that incident on 1/3/25. -She did investigate the incident once it came to her attention. -She did not put the incident into IRIS once the abuse allegation came to her attention. -The Case Manager was responsible for putting incidents into IRIS. -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 500	Continued From page 13 reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 500	Continued From page 14 restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). The findings are: Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed: -"On 1/4/25 [client #1] told [staff #2] that [staff #1] hit her, threw her to the ground & broke her glasses. [Client #1] showed [staff #2] the break in the glasses frame and where she was hit on her side. She showed me 2 scratches on her arms where she said [staff #1] scratched her, pulling off her shirt." Review on 1/21/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against staff #1 related to the 1/3/25 incident with client #1. Interviews on 1/16/25 and 1/21/25 with the Executive Director/Qualified Professional	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 500	Continued From page 15 revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #2 called her on 1/4/25 and reported client #1 told her that staff #1 hit her and broke her glasses during that incident on 1/3/25. -She did investigate the incident once it came to her attention. -She confirmed the agency failed to report the above allegations of abuse to DSS.	V 500		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of	V 537	Executive Director will discuss additional training with a certified instructor to provide additional training for staff in seclusion, physical restraint and isolation time-out for clients when violent.	1/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 16 training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, 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: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) 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); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety 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; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures.(h) Service providers shall maintain	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 17 documentation of initial and refresher 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 they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 18 (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course 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.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 19	V 537		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure staff was trained in a restrictive intervention prior engaging in a physical restraint for one of four audited staff (#1). The findings are:

Review on 1/17/25 of staff #1's personnel record revealed:
-Date of hire was 9/14/22.
-Hired as a Support Staff.
-North Carolina Intervention (NCI) Plus-Prevention completed on 5/15/24. -No documentation of training in the use of seclusion, physical restraints and isolation time-out training.

Review on 1/17/25 of client #1's record revealed:
-Admission date of 4/3/23.
-Diagnoses of Moderate Intellectual Disability, Overweight and Acanthosis Nigricans.

Review on 1/21/25 of an in-house incident report dated 1/3/25 revealed:
-"When [staff #1] walked through Group Home (gh) 2 doors [the Group Home Manager] told [staff #1] that [client #1] had on her new clothes and wouldn't change into old clothes. [Staff #1] asked [client #1] to take the new clothes off and put the old clothes on. [Client #1] started cussing at both staff...When [client #1] got up she started cussing and swinging at [staff #1]...[Client #1] was still trying to hit and talking junk to [staff #1]. [Staff #1] grabbed [client #1] and got her to the ground with her hands over her head...[Client #1] got one of her hands loose from moving her body

V 537	Continued From page 20 around. When [client #1's] arm was loose [client #1] was trying to hit [staff #1] and scratched herself behind her left ear and neck and left arm/shoulder...[Client #1] grabbed her glasses off her face rough and cracked the frame..." Interview on 1/21/25 with client #1 revealed: -She had no recent incidents with staff at the facility. -Staff at the facility did not put her in a therapeutic hold. -She had no recent injuries at the facility. -She wasn't wearing her glasses because they were at a local store being repaired. -She wasn't sure how her glasses were broken. Interview on 1/16/25 with staff #1 revealed: -There was an incident with client #1 towards the beginning of January 2025 (1/3/25). -She walked into the facility and the Group Home Manager said client #1 would not take off her new clothing. -She asked client #1 to take off the clothing and client #1 refused. -She then placed her hand on client #1's shoulder to prompt her get out of the chair and go to her bedroom to change her clothes. -Client #1 said "I'm not changing my m****r f******g shirt." -Client #1 stood up and got into her face. -Client #1 then swung at her. -She and client #1 were facing each other and she grabbed client #1 by both arms. -She took client #1 down to the floor. -"I can't remember how I took [client #1] down to the floor because it happened so fast." -When client #1 went down to the floor she was lying on her stomach. -Client #1 took off her eye glasses and slammed them onto the floor and broke them.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 21 -She then took client #1's arms and put them above her head. -"I knew I was not supposed to do a hold on [client #1], but [client #1] would not stop swinging at me." -"We are not trained to do holds on clients with this agency." -"I was trained in the 2nd part of NCI with another agency." -Client #1 did have a few "minor" scratches after the incident. -Client #1 had a scratch behind her ear. -Client #1 had two-three scratches on her left shoulder. Interview on 1/16/25 with the Group Home Manager revealed: -She witnessed the incident between client #1 and staff #1 at the beginning of January 2025 (1/3/25). -Client #1 came into the den area wearing some of the clothes she received for Christmas. -She told client #1 that she should take off the clothing and save the clothing to wear to the day program. -Client #1 refused to take off the clothing. -A few minutes later staff #1 walked into the facility. -She told staff #1 about client #1 refusing to take off her new clothing. -Staff #1 asked client #1 to change her clothes. -Client #1 was sitting in a chair. She saw staff #1 approach client #1 and pull at client #1's shirt. -"It looked like [staff #1] was trying to pull up [client #1's] shirt. -Client #1 then stood up and swung at staff #1 and tried to bite her. -They both went down to the floor. -Client #1 fell onto her stomach. -Staff #1 was straddling client #1's back.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-027	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COUNTY GROUP HOME #2	1011 WEST FIFTH STREET SILER CITY, NC 27344

(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 537	Continued From page 22 -Staff #1 had a knee on the floor on both sides of client #1's body. -Staff #1 was not laying on client #1. -Staff #1 held client #1's hands behind her back. -She couldn't remember exactly how staff #1 was holding client #1's hands. -"I just know they were behind her back." - Client #1 kept calling staff #1 a "b***h" and saying get off of me. -She recalled client #1's glasses being broken after the incident,. -She did not see how client #1's glasses were broken. -She didn't recall seeing any bruises or scratches on client #1 after the incident. Interview on 1/16/25 with the Executive Director/Qualified Professional revealed: -There was an incident on 1/3/25 with client #1 and staff #1. -She was told client #1 was being aggressive towards staff #1. -She was told client #1 hit staff #1. -Staff #1 said she put client #1 in a therapeutic hold. -Staff #1 said she knew this agency did not do restraints." -Staff #1 said client #1 would not stop hitting her. - Staff #1 said she put client #1's arms over her head and sat down on the floor with her. -"This agency does not use therapeutic holds if a client is being aggressive."	V 537		