Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FEATURE CONTROL			A. BUILDING:				
MHL019-027		B. WING		C 03/13/2025			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CHATHAM COUNTY GROUP HOME #2 1011 WEST FIFTH STREET SILER CITY, NC 27344							
(EACH DEFICIENCY	MUST BE PREC	EDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE DATE	
V 000 INITIAL COMMENTS			V 000				
A complaint survey was completed on March 13, 2025. The complaint was substantiated (intake #NC00226627). A deficiency was cited.							
This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.							
census of 5. The su	ırvey sample						
27G .5603 Supervised Living - Operations			V 291				
(a) Capacity. A fact six clients when the developmental disation June 15, 2001, at than six clients at the provide services at licensed capacity. (b) Service Coording maintained between qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in a conference and shaprogress toward medical disable progress to the	cility shall serve clients have bilities. Any fand providing nat time, may no more than attion. Coord the facility of als who are ron or case mathe Family or n. Each clien are facility and so shall be subject of a minor person of an writing or take all focus on the eting individual.	we no more than mental illness or facility licensed services to more continue to a the facility's dination shall be perator and the esponsible for anagement. Legally through such divisits outside mitted at least resident, or the adult resident. The the form of a secilent's ual goals.					
The second of th	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE INITIAL COMMENT A complaint survey 2025. The complaint #NC00226627). A complaint survey 2025. The complaint for Adults wit This facility is licens category: 10A NCA Living for Adults wit This facility is licens category: 10A NCA Living for Adults wit This facility is licens category: 10A NCA Capacity. A fact six clients when the developmental disa on June 15, 2001, a than six clients at the provide services at licensed capacity. (b) Service Coordin maintained between qualified profession treatment/habilitatio (c) Participation of Responsible Person provided the opport relationship with he means as visits to t the facility. Reports annually to the pare legally responsible Reports may be in the conference and sha progress toward me (d) Program Activit (d) Program Activit	SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING INITIAL COMMENTS A complaint survey was complete (2025. The complaint was substate (#NC00226627). A deficiency was (Initial facility is licensed for the follocategory: 10A NCAC 27G .5600) (Living for Adults with Development (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample audits of 1 current client. (Initial facility is licensed for 6 and census of 5. The survey sample facility is licensed capacity. (Initial facility is licensed for 6 and census of 5. The survey sample facility of 5. The survey sample facility of 6. The survey sample facility	MHL019-027 ROVIDER OR SUPPLIER STREET ADI 1011 WES SILER CIT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on March 13, 2025. The complaint was substantiated (intake #NC00226627). A deficiency was 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 1 current client. 27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's	MHL019-027 STREET ADDRESS, CITY, STREET, ST	MHL019-027 STREET ADDRESS, CITY, STATE, ZIP CODE 1011 WEST FIFTH STREET SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES PREFIX FAGO CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) V 000 A complaint survey was completed on March 13, 2025. The complaint was substantiated (intake #NC00226627). A deficiency was 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 1 current client. 27G. 5603 Supervised Living - Operations 10A NCAC 27G. 5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the gally responsible person of an adult resident. Reports may be in writing or	MHL019-027 MHL019-027 MHL019-027 STREET ADDRESS, CITY, STATE, ZIP CODE 1011 WEST FIFTH STREET SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on March 13, 2025. The complaint was substantiated (intake MNC00226627). A deficiency was 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 1 current client. 27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's icensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have	

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BUILDING:			_	
		MHL0	19-027	B. WING			C 13/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
CHATHA	CHATHAM COUNTY GROUP HOME #2 1011 WEST FIFTH STREET SILER CITY, NC 27344							
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
V 291	Continued From particles and the treat Activities shall be dinclusion. Choices or legal system is it safety issues become	tment/habilita esigned to fo may be limit nvolved or wl	oster community ed when the court hen health or	V 291				
	This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure coordination of services for one of one audited client (#1). The findings are:							
	Review on 3/13/25 of client #1's record revealed: -Admission date of 4/3/23Diagnoses of Moderate Intellectual Disability, Overweight and Acanthosis Nigricans.							
	Review on 3/13/25 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."							
	Interview on 3/13/2 revealed: -The Executive Dire (ED/QP) called her that occurred on 1/#1She was informed physical restraint"[The ED/QP] gave it took them about 2	ector/Qualifie on 1/21/25 a 3/25 with clie staff #1 put e me no expl	ed Professional about an incident ent #1 and staff client #1 in a anation as to why					

Division of Health Service Regulation

STATE FORM 6899 KQI211 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING.		C			
MHL019-027		B. WING		03/13/2025				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
СНАТНА	CHATHAM COUNTY GROUP HOME #2 1011 WEST FIFTH STREET							
			TY, NC 2734					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE		
V 291	Continued From pa	ige 2	V 291					
	the incident."							
	Coordinator revealed. She received a care 1/21/25Client #1's guardia incident with client she was informed towards staff#1She was informed therapeutic hold for staff from client #1 emailed her about she tried to follow Manager about the she emailed both response."	Il from client #1's guardian on an reported there was an #1 at the facility. client #1 was aggressive "[staff #1] put [client #1] into a rabout a minute." I's facility never called or this incident. up with the ED/QP and Case incident. of them and "never got a details related to the incident						
	Interview on 3/13/25 with the Case Manager revealed: -"If there is an incident with a client, I am responsible for reporting the incident to the guardian." -She reported the 1/3/25 incident with client #1 and staff #1 to the guardian on 1/21/25The ED/QP called the guardian, and they both reported the incident via telephone"We normally report the incidents immediately." -"There was a lot of up and down with the incident and that was why it was not reported to the guardian on 1/3/25." -She didn't contact client #1's Care Coordinator about the 1/3/25 incident. Interview on 3/13/25 with the ED/QP revealed:							
-The 1/3/25 incident with client #1 and staff #1								

Division of Health Service Regulation

was reported to client #1's guardian.

STATE FORM 6899 KQI211 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
MHL019-027		B. WING		1	C 03/13/2025			
NAME OF I	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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 291	Continued From pa	ge 3	V 291					
V 291	-She talked to clien 1/27/25She reported the ir -"The incident was not remember why -She told the Case when it occurred or -She was not sure to report the incider	t #1's guardian on 1/21/25 and necident "on one of those days." reported late and she could it was not reported sooner." Manager to report the incident in 1/3/25. why the Case Manager failed in the when it occurred on 1/3/25. client #1's Care Coordinator	V 291					

6899

Division of Health Service Regulation STATE FORM

KQI211 If continuation sheet 4 of 4