STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-107	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

(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 survey was completed on January 16, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.	V 000	PLEASE SEE ATTACHED Documentation Q.P. DHSR - Mental Health FEB 03 2020 Lic. & Cert. Section	1-20-20
V 112	27G .0205 (C-D) 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 annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-107	A. BUILDING: _____ B. WING _____	01/16/2020

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TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, the facility Management failed to have current treatment plans to address client needs affecting 1 of 2 current clients (#2). The findings are: Review on 1/16/20 of Client #2's record revealed the following information; -- 51 year old male. -- Admitted to the facility on 3/14/03. -- Diagnoses include Mild Mental Retardation, Impulse Control Disorder and Hypertension. Review on 1/16/20 of Client #2's treatment plan dated 12/2/18 revealed a goal of attending a psychosocial rehabilitation program and obtaining his own housing. Documentation on this treatment plan indicates both of these goals have been "achieved." Interview on 1/16/20 with the Qualified Professional/Licensee revealed the following information; -- He was aware that there was not a current treatment plan. -- The client was planning to move into independent living within the next two weeks.	V 112	PLEASE REVIEW ATTACHED Documentation Q.P	1/20/20
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-107	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

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V 113	Continued From page 2 (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on interview and record review, the facility	V 113	PLEASE REVIEW ATTACHED DOCUMENTATION EDe QP	1/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

(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 113	Continued From page 3 Management failed to have any documentation of services provided, or progress towards these outcomes affecting 2 of 2 current clients (#1 #2). The findings are: Review on 1/16/20 of Client #1's record revealed the following information; -- 39 year old male. -- Admitted to the facility on 3/29/17. -- Diagnoses include Mild Mental Retardation, Schizophrenia, Hypertension and Vitamin D deficiency. -- No documentation of services provided or progress made toward his goals. Review on 1/16/20 of Client #2's record revealed the following information; -- 51 year old male. -- Admitted to the facility on 3/14/03. -- Diagnoses include Mild Mental Retardation, Impulse Control Disorder and Hypertension. -- No documentation of services provided or progress made toward his goals. Interview on 1/16/20 with the Qualified Professional/Licensee revealed the following information; -- He was not aware that there was a requirement of documentation of services provided or progress made toward goals. -- He had never been asked by other surveyors for 'progress notes.' -- He would begin doing a monthly summary for each client with the required documentation.	V 113	PLEASE REVIEW ATTACHED Documentation	1/20/20
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

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V 114	Continued From page 4 (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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 interview and record review, the facility Management failed to assure that fire and disaster drills were held at least quarterly on each shift. The findings are; Review on 1/16/20 of the facilities fire/disaster log revealed the following information; -- There were 5 fire drills held and all of them were on 1st shift. -- There were 8 disaster drills held and all of them were on either 2nd or 3rd shift. Interview on 1/16/20 with the Qualified Professional/Licensee revealed the following information; -- He was not aware that these drills were not being performed as required by rule. -- He would implement a system to assure that the drills were performed.	V 114	PLEASE REVIEW ATTACHED Documentation Q.P.	1/20/20

NAME OF PROVIDER: TRIAD HEALTHCARE 1

STREET ADDRESS, CITY, STATE, ZIP CODE: 706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT P-14 BURLINGTON, NC 27215

PROVIDER IDENTIFICATION NUMBER: MHL-001-107

PLAN OF CORRECTION

ID PREFIX TAG: V 112

DEFICIENCY: THE FACILITY MANAGEMENT FAILED TO HAVE CURRENT TREATMENT PLANS TO ADDRESS CLIENT NEEDS.

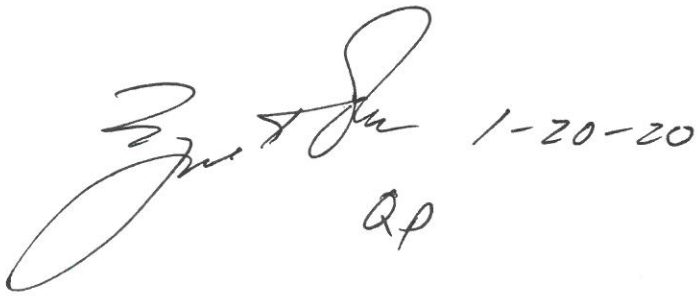
PROVIDERS PLAN OF CORRECTION

ID PREFIX TAG: V 112

MEASURES PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PRACTICE:

1. ON 1-17-20, FACILITY MANAGEMENT ALONG WITH CLIENT REVIEWED AND UPDATED CLIENT'S TREATMENT PLAN GOAL. CLIENT STILL PLANS TO MOVE WITHIN 7 DAYS TO HIS OWN APARTMENT.
2. **WHO WILL MONITOR/HOW OFTEN: QP WILL MONITOR ALL TREATMENT PLANS** ON A **WEEKLY AND OR MONTHLY** BASES AS TO ENSURE ALL TREATMENT PLANS HAVE NOT EXPIRED AND REMAIN UPDATED.QP WILL SCHEDULE A REVIEW OF THE PLAN WITH THE CLIENT OR LEGALLY RESPONSIBLE PERSON OR BOTH PARTIES. QP AND CLIENT/LEGALLY RESPONSIBLE PARTY WILL COORDINATE TOGETHER TO ENSURE ALL GOALS ARE REVIEWED, ONCE A GOAL IS ACHIEVED QP AND CLIENT WILL DISCUSS ADDING ADDITIONAL GOALS.
3. **ADDITIONAL MEASURES PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURRING AGAIN STAFF/QP WILL MONITOR CLIENT TREATMENT PLAN MONTHLY** TO ENSURE THAT TREATMENT PLANS HAVE NOT EXPIRED.

DEFICIENCY CORRECTED ON 1-17-20



1-20-20

QP

DHSR - Mental Health

FEB 03 2020

Lic. & Cert. Section

PROVIDERS PLAN OF CORRECTION

ID PREFIX TAG: V 113

DEFICIENCY: MANAGEMENT FAILED TO HAVE ANY DOCUMENTATION OF SERVICES PROVIDED, OR PROGRESS TOWARDS OUTCOMES.

MEASURES PUT IN PLACE TO CORRECT THE DEFICIENT AREA OF PREACTICE: RESIDENTIAL STAFF WILL BE RESPONSIBLE FOR DOCUMENTING WEEKLY/MONTHLY PROGRESS DOCUMENTATION OF SERVICE PROVIDED OR PROGRESS TOWARDS OUTCOMES OF GOALS AFFECTING CLIENTS. (PROGRESS NOTE) TO ENSURE PROGRESS TOWARDS GOALS ON TREATMENT PLAN, DAILY BEHAVIORAL ISSUES AND OUTCOMES AFFECTING CLIENTS ARE MET. PROGRESS NOTES WILL BE COMPLETED BY STAFF.

MEASURES PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURRING AGAIN: **QP WILL MONITOR RESIDENTIAL STAFF MONTHLY** TO ENSURE DOCUMENTATION IS COMPLETED BY RESIDENTIAL STAFF.

WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN: **QP WILL MONITOR RESIDENTIAL STAFF MONTHLY** TO ENSURE STAFF HAS COMPLETED DOCUMENTATION/PROGRESS NOTES TOWARDS CLIENT OUTCOME?

HOW OFTEN THE MONITORING WILL TAKE PLACE: **MONTHLY** BY QP

DEFICIENCY CORRECTED ON 1-17-20

FACILITY TO BEGIN DOING MONTHLY SUMMARY FOR EACH CLIENT WITH THE REQUIRED DOCUMENTATION

SAMPLE MONTHLY PROGRESS NOTE PROVIDED: SEE ATTACHED COPY OF MONTHLY PROGRESS NOTE

QP 1-20-20

PLAN OF CORRECTION

PREFIX TAG: V 114

DEFICIENCY: MANAGEMENT FAILED TO ASSURE THAT FIRE AND DISASTER DRILLS WERE HELD AT LEAST QUARTERLY ON EACH SHIFT.

MEASURE PUT IN PLACE TO CORRECT THE DEFICENT AREA OF PRACTICE: **RESIDENTIAL STAFF WILL REVIEW/MONITOR** FIRE AND DISASTER DRILL LOG **MONTHLY.** STAFF WILL ENSURE DRILLS WILL BE HELD AT LEAST QUARTERLY ON EACH SHIFT. (QP FEELS HE WAS FOLLOWING THE QUARTERLY SCHEDULE OF COMPLETING DRILLS EVERY QUARTERLY FOR EACH TYPE OF DISASTER) FACILITY WILL UPGRADE A NEW DRILL SYSTEM TO ENSURE THAT DRILLS WILL BE COMPLTED ON EACH SHIFT. STAFF WILL PERFORM 3 FIRE, 3 HURRICANE AND 3 EARTHQUAKE DRILL PER QUARTER ON EACH SHIFT TO ENSURE DRILLS ARE BEING PERFORMED. FACILITY WILL ADD BOMB THREATS, FLOOD, POWER OUTTAGE PROCEDURES AS WELL

MEASURE PUT IN PLACE TO PREVENT THE PROBLEM FROM OCCURRING AGAIN: STAFF WILL COORDINATE WITH QP TO REVIEW FIRE AND DISASTER DRILL LOG TO ENSURE ALL DRILLS ARE COMPLETED PER SHIFT.

WHO WILL MONITOR THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN: STAFF WILL MONITOR FIRE AND DISASTER DRILL PERFORMACE **MONTHLY**?

HOW OFTEN THE MONITORING WILL TAKE PLACE: MONTHLY

DEFICIENCY COMPLETE DATE: 1-20-20

QP. 1-20-20

MONTHLY PROGRESS REPORT

CLIENT:
SOCIAL WORKER:
MONTH/YEAR:
PLACEMENT:
COMPLETED BY:

ACADEMIC (performance in school, grades, services provided by school and placement to address academic needs):

BEHAVIORAL (interactions with peers and adults, recurring problem behaviors, identified antecedents, successful interventions used with client):

EMOTIONAL/PSYCHOLOGICAL (note client's reaction/adjustments to stressor change, coping skills client employs, impairments in emotional function or well-being):

THERAPY/INTERVENTIVE SERVICES (indicate who is providing service, type of service, issues being addressed in treatment, changes in diagnoses if applicable):

SELF-CARE ISSUES/CONCERNS (development of age-appropriate skills for dressing, eating, hair care, hygiene):

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 23, 2020

Byron White, Licensee
Triad Health Care 1
PO Box 3334
Burlington, NC 27215

Re: Annual Survey completed January 16, 2020
Triad Health Care 1, 706 Huffington Mill Rd. Bldg P, Apt 14 Burlington NC 27215
MHL # 001-107
E-mail Address: byronkeith2001@yahoo.com

Dear Mr. White:

Thank you for the cooperation and courtesy extended during the annual survey completed January 16, 2020.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies> must be ***corrected*** within 60 days from the exit of the survey, which is March 16, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call the South Piedmont Team Leader, Mr. Bryson Brown at (919) 855-3822.

Sincerely,

Johanna Edwards RN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: gmemail@cardinalinnovations.org
Pam Pridgen, Administrative Assistant