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	mhl010-057	A. BUILDING: _____ B. WING _____	R 11/18/2022

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THE TRINITY HOME	1117 OLD FAYETTEVILLE ROAD LELAND, NC 28451

(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 follow up survey was completed on November 18, 2022. 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 2 current clients.	V 000		
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		

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This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop client treatment plans as required and to obtain written consent at least annually by the client for 3 of 3 audited clients (#1, #2, #3). The findings are:

Finding#1:
Review on 11/16/22 and 11/17/22 of client #1's record revealed:
-49 year old female admitted 3/24/09.
-Diagnoses included mild intellectual developmental disabilities, bipolar, and depression.
-Client #1 was her own guardian.
-Most recent treatment plan dated and signed was documented to begin 6/1/21 and signed by the client on 5/4/21.

Observation on 11/16/22 between 3:30 pm and 4 pm revealed client #1 was in her bedroom and could not hear or speak to surveyor.

Interview on 11/16/22 with client #1 revealed:
-She was able to communicate minimally in writing and with some assistance with Staff/Qualified Professional (QP) #1.
-She had no concerns and was very happy living in the facility.

Finding #2:
Review on 11/16/22 and 11/17/22 of client #2's

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V 112	Continued From page 2	V 112		

record revealed:
-33 year old male admitted 4/25/09.
-Diagnoses included mild intellectual developmental disabilities, post traumatic stress disorder, attention deficit hyperactive disorder, history of sexual abuse.
-Client #2 was his own guardian.
-Most recent treatment plan dated and signed was documented to begin 6/1/21 and signed by the client on 5/4/21.

Finding #3:
Review on 11/16/22 and 11/17/22 of client #3's record revealed:
-53 year old male admitted 10/5/13.
-Diagnoses included severe intellectual developmental disabilities and autism.
-Client #3 was listed as his own guardian.
-Most recent plan dated to begin 5/1/21.
-No current plan signed by client #3.
-No goals or strategies documented to assess/address client #3's competency deficits.

Observation and interview on 11/16/22 at 5 pm of client #3 revealed:
-Client #3's head and hands trembled constantly as he continuously held onto the hem of his shirt.
-When asked simple questions to include who cooked his food he gave the name of his brother and another word that did not relate to the facility or the facility staff.

Interview on 11/17/22 Staff #3 stated:
-Client #3 was not able to make decisions without "a lot of guidance."
-Client #3 could ambulate independently, use the toilet and flush, but would not wash his hands without staff prompting.

Interview on 11/17/22 the Staff/QP#1 stated:

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V 112	Continued From page 3 -She thought the care coordinator had sent forms for clients to sign their plans for the current year, but could not locate them in the client records. -Treatment teams had been held virtually. -Client #3 was not competent enough to make important decisions to include medical decisions. -Client #3 did not have a guardian. -Client #3's brother was incarcerated and did not prepare the client's food. -The word client #3 used during his interview to answer questions, other than his brother's name, was where he lived prior to admission to the facility. -Client #3's lack of competency and lack of a guardian had never been discussed by the treatment team.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (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:	V 114		

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V 114	Continued From page 4 Based on interview and record review, the facility failed to hold fire and disaster drills at least quarterly on each shift that simulated a fire or disaster. The findings are: Review on 11/17/22 of fire and disaster drills between 10/1/21 and 9/30/22 revealed: -10/1/21-12/31/21: Staff/Qualified Professional(QP) #1 documented all fire and disaster drills for 1st and 3rd shifts as follows: -10/21/21: Fire drills at 6:30am and 10am -10/15/21: Hurricane drills at 6:15am and 8:15am -10/15/21: Tornado drills at 6:30am and 8:30am -1/1/22 - 3/31/22: Staff/QP #1 documented all fire and disaster drills for 1st and 3rd shifts as follows: -1/9/22: Fire drills at 6am and 2:45pm -1/14/22: Hurricane drills at 6:15am and 7:30am -1/14/22: Tornado drills at 6am and 8:30am -4/1/22 - 6/30/22: Staff/QP #1 documented all fire and disaster drills for 1st and 3rd shifts as follows: -4/17/22: Fire drills at 6am and 11:30am -4/16/22: Hurricane drills at 5:15am and 9:30am -4/16/22: Tornado drills at 5am and 9:15am -7/1/22 - 9/30/22: Staff/QP #2 documented fire drills for 1st and 3rd shifts on 7/18/22 at 6:30am and 6:30pm. -7/1/22 - 9/30/22: Staff/QP #1 documented all disaster drills for 1st and 3rd shifts as follows: -7/17/22: Hurricane drills at 6:10am and 8:40am -7/17/22: Tornado drills at 6am and 8:30am Interview on 11/17/22 Staff #3 stated: -She had worked at the facility "about 10 years."	V 114		

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V 114	Continued From page 5 -She worked the night shift, 11pm -7am. -She was the only night shift staff. -Fire and disaster drills took place on the "other 2 shifts," but she was aware of what needed to be done. -She did not do fire or disaster drills. Interview on 11/17/22 Staff/QP #1 stated: -The facility had 3 shifts as follows: 1st (day) shift = 7am-3pm, 2nd (evening) shift = 3pm-11pm, and 3rd (night) shift = 11pm-7am. -If a fire or disaster were to occur on the third shift, Staff #3 would be the only staff on duty. -The night staff did not do fire or disaster drills. -Either Staff/QP #1 or Staff/QP #2 would do all of the fire and disaster drills. -The reason Staff/QP #1 or Staff/QP #2 held all of the drills was because there were so many required and they were trying to make sure all required drills were done. -She had not thought about the night shift drills always done by the day and evening shift staff did not simulate what would happen if a real fire or disaster were to occur on that shift.	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials	V 117		

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V 117	Continued From page 6 with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure all prescription medications had a pharmacy label with all required information affecting 1 of 3 clients audited (#1). The findings are: Review on 11/16/22 of client #1's record revealed: -49 year old female admitted 3/24/09. -Diagnoses included mild intellectual developmental disabilities, bipolar, and depression. -Medication Administration Records dated September, October, and November 2022 documented an order for Proair HFA (hydrofluoroalkane) INH (inhaler) 2 puffs every 4 hours for wheezing and shortness of breath.	V 117		

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V 117	Continued From page 7 Observation on 11/16/22 at 4:38 pm revealed: -An unlabeled Proair HFA 90 mcg (micrograms) inhaler inside a plastic bag stored in the locked box with client #1's medications. -No box or other container with a label for the Proair HFA 90 mcg inhaler. Interview on 11/17/22 Staff/Qualified Professional #1 stated: -Client #1's inhaler probably was dispensed in a box that had been labeled. -She had an inhaler at the day program and kept this inhaler in the home or took it when she went into the community.	V 117		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives,	V 536		

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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 wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing 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

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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 Qualifications 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 a passing grade on testing in an instructor training program.
(3) 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.
(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.
(5) Acceptable instructor training programs 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

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V 536	Continued From page 10 review by the coach. (7) 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 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure annual refresher training on alternatives to restrictive interventions for 2 of 3 staff audited (Staff/Qualified Professional #2,	V 536		

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V 536	Continued From page 11 Staff #3). The findings are: Review on 11/17/22 of Staff/Qualified Professional (QP) #2's personnel file revealed: -Hire date was 6/1/2007. -Direct care staff for the 3 pm -11 pm shift and a Qualified Professional. -No documentation of approved training on alternatives to restrictive interventions between 11/17/21 and 11/17/22. Review on 11/17/22 of Staff #3's personnel file revealed: -Hire date was 6/1/2007. -Direct care staff for the 11 pm -7 am shift. -No documentation of approved training on alternatives to restrictive interventions between 11/17/21 and 11/17/22. Review on 11/17/22 of Staff/(QP) #1's personnel file revealed: -Hire date was 3/1/2007. -Direct care staff for the 7 am -3 pm shift and a Qualified Professional. -No documentation of approved training on alternatives to restrictive interventions between 11/17/21 and 11/17/22. Review on 11/18/22 of Staff/(QP) #1's card dated 12/18/21 documented completion of alternatives to restrictive interventions training. Interview on 11/17/22 Staff/QP #1 stated: -Restrictive interventions were not used in the facility. -She had received annual training for alternatives to restrictive interventions through her employment with a licensed day program attended by the facility clients. -She had been unsuccessful in finding a place	V 536		

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V 536	Continued From page 12 that would provide training for the other staff during the pandemic. -The facility had not designated a curriculum to be used for staff training on alternatives to restrictive interventions. -She did not realize the facility had to choose a curriculum and require all staff to obtain the training using that curriculum. -She would email the surveyor a copy of her card documenting current training for alternatives to restrictive interventions.	V 536		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.	V 540		

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This Rule is not met as evidenced by:
Based on record review, observation, and interview, the facility did not ensure client's rights to have linens provided by the facility affecting 1 of 3 clients audited (client #2). The findings are:

Review on 11/16/22 of client #2's record revealed:
-33 year old male admitted 4/25/09.
-Diagnoses included mild intellectual developmental disabilities, post traumatic stress disorder, attention deficit hyperactive disorder, history of sexual abuse.
-Client #2 was his own guardian.
-Client #2's goals included maintaining living skills by completing household chores with verbal prompts by staff.

Observations on 11/16/22 between 3:30 pm and 4 pm, and 11/17/22 at approximately 1:30 pm revealed:
-There was a comforter partially covering client #2's bed.
-Client #2's mattress could be seen on entry into his room and there were no sheets on the bed.

Interviews on 11/16/22 and again on 11/17/22 client #2 stated:
-His sheets had been torn and were discarded.
-He did not have sheets for his bed because he had not purchased any replacement sheets.
-It was his responsibility to provide his own linen.
-The facility did not provide him with bed linen.

Interview on 11/17/22 Staff/Qualified Professional #1 stated:
-She was not aware client #2 did not have sheets.
-The facility provided linen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl010-057	A. BUILDING: _____ B. WING _____	R 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TRINITY HOME	1117 OLD FAYETTEVILLE ROAD LELAND, NC 28451

(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 540	Continued From page 14 -There was no explanation why linen had not been provided.	V 540		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner, free from offensive odor. The findings are: Observations on 11/16/22 between 3:30 pm and 4 pm revealed: -Steps to the front entrance covered with a black residue. -Siding over the front stoop eaves detached, exposing openings above both sides of the front entry door. -Top surface of at least 3 floor tiles in dining room had worn exposing a black underside. -Dust visible, adhering to textured ceiling above dining table ceiling fan. -Spatter stains visible on the outside surfaces of lower cabinets in kitchen. -Dust build up visible on air return vent in hall. -Client #2's room: Odor similar to that of old shoes was present. Dust ruffle frayed at the foot of the bed. No sheets on the mattress.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 15 -Hall bathroom: dust build up visible on window blinds, window horizontal surfaces, and tile baseboards; gray staining of door facings at the level of the light switch; and, spatter staining on closet doors. -Client #1's room: Offensive pungent odor; 3 of 8 dresser drawers off track; bathroom wall paper peeling/torn above the door, near tub and window, along the baseboard; no stopper in one sink; toilet lid did not cover toilet rim and no seat was visible; smudged brown staining around the bathroom light switch and on the bathroom window frame; only 1 of 4 ceiling fan lights worked (1 was missing the bulb). -Client #3's room: bedroom door covered with brown worn tape. Interview with staff #1/Qualified Professional: -Repairs would be done. -Client #1 would overstuff her dresser drawers and cause them to get off track. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl010-057	A. BUILDING: _____ B. WING _____	R 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TRINITY HOME	1117 OLD FAYETTEVILLE ROAD LELAND, NC 28451

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V 752	Continued From page 16 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure temperature of the water was maintained between 100-116 degrees Fahrenheit in all areas of the facility where clients were exposed to hot water. The findings were: Observations between 3:30 pm and 4 pm on 11/16/22 revealed hot water temperatures as follow: -Kitchen sink = 120 degrees Fahrenheit -Hall bathroom sink = 122 degrees Fahrenheit -Hall tub faucet = 124 degrees Fahrenheit -Client #1's sink and tub faucets = 120 degrees Fahrenheit Interview on 11/17/22 Staff #3 stated: -She had not noticed the water being too hot. -Client #3 never accessed the hot water without staff assistance. -The hot water heater had been replaced recently. Interview on 11/17/22 Staff/Qualified Professional #1 stated: -She was not aware the hot water temperatures were too hot.	V 752		