

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411246	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/03/2026
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NAME OF PROVIDER OR SUPPLIER TRISTON DRIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 TRISTON DRIVE GREENSBORO, NC 27407
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A follow up and complaint survey was completed on 6/3/26. The complaint was unsubstantiated (intake # NC00237129). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> (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 	V 367		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 367	<p>Continued From page 1</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p>	V 367		

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V 367	<p>Continued From page 2</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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 (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report all level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) in the catchment area within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 6/2/26 of local "911 Communications" revealed:</p> <ul style="list-style-type: none"> - Date 4/12/26 - Caller: staff #4 - "Name: [Former Client (FC) #4]" - "Client (FC #4) wandered off. Has dementia, caretaker has eyes on him but needs help getting hm back home due to another client being in home." 	V 367		

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V 367	<p>Continued From page 3</p> <p>Review on 6/3/26 of "Internal Incident Report" revealed:</p> <ul style="list-style-type: none"> - Date of Incident: 4/12/26 - Time: 10:00 am - Client name: FC #4 - "Type of Incident: runaway" - "[FC #4] was upset about not being able to have someone take him to church. He left home, wandered ignoring staff. Walked off with the mission to get to church. [FC #4] ignored prompts from staff. He did not stop. Staff called 911..." <p>Review on 6/3/26 of the North Carolina Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No level II incident report was submitted to IRIS for the 4/12/26 incident. <p>Interview on 6/3/26 with the Qualified Professional/Residential Supervisor revealed:</p> <ul style="list-style-type: none"> - An IRIS report was not completed because the police were called "but (the police) did not have to find [FC #4]." 	V 367		