STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G310	A. BUILDING _____ B. WING _____	C 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC CHEROKEE TRAIL GROUP HOME	105 CHEROKEE TRAIL WILMINGTON, NC 28409

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation was completed on 10/9/18. Complaint Intake # NC00143466. The complaint was not substantiated.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews with staff, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within twenty four hours as required by N.C. General Statute 131E-256, which is under 131E Article 15. The finding is: Facility management staff failed to report allegations of abuse to HCPR as required by state law. Review on 10/9/18 of an inquiry completed by the Director of Professional Services on 5/9/18 revealed the following: One of the direct care staff wrote a six page letter to the Corporate office in May. She expressed concerns that one of the direct care staff who worked at the facility was overly demonstrative with one of the clients . There are cameras throughout the hallways, dining room and living room of the home. There are not cameras in the bedrooms of the clients. Several direct care staff were interviewed. Three	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
LIFE, INC CHEROKEE TRAIL GROUP HOME	105 CHEROKEE TRAIL WILMINGTON, NC 28409

(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) COMPLETION DATE
W 153	Continued From page 1 clients were also interviewed. There were allegations in this letter that a direct care staff was holding client #4s hand, called him her "boyfriend" and did not follow his behavior support plan (BSP). There was a specific allegation that this direct care staff may have attempted a sexual encounter with client #4.. The camera footage in all areas of the facility was viewed and all staff were re questioned. No evidence throughout this process was presented to substantiate any of these allegations. The local department of social services was notified and conducted an external investigation. The facility did not substantiate these allegations. A decision was made to retrain staff and re assign this staff member to another facility. Interview on 10/8/18 with the qualified intellectual disabilities professional (QIDP) and the Director of Professional Services confirmed they did not contact HCPR regarding these allegations.	W 153		