DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LIFE, INC CHEROKEE TRAIL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 105 CHEROKEE TRAIL WILMINGTON, NC 28409 PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					
NAME OF PROVIDER OR SUPPLIER LIFE, INC CHEROKEE TRAIL GROUP HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS A desk review complaint survey was completed on 10/29/2020. Deficiencies were not cited as a result of the complaint survey for Intake #NC00170547. The complaint allegation was			24G240						
LIFE, INC CHEROKEE TRAIL GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS A desk review complaint survey was completed on 10/29/2020. Deficiencies were not cited as a result of the complaint survey for Intake #NC00170547. The complaint allegation was				B. WING -				10/29/2020	
LIFE, INC CHEROKEE TRAIL GROUP HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) WILMINGTON, NC 28409 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 000 INITIAL COMMENTS W 000 A desk review complaint survey was completed on 10/29/2020. Deficiencies were not cited as a result of the complaint survey for Intake #NC00170547. The complaint allegation was	NAME OF PE	ROVIDER OR SUPPLIER				DDE			
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on 10/29/2020. Deficiencies were not cited as a result of the complaint survey for Intake #NC00170547. The complaint allegation was	W 000	00 INITIAL COMMENTS		W	000				
		on 10/29/2020. Deficient of the complaint #NC00170547. The complaint #NC00170547.	ciencies were not cited as a nt survey for Intake						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)								X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.