STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL028-013	A. BUILDING: _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE TRAIL FACILITY	185 ROANOKE TRAIL MANTEO, NC 27954

(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 A complaint survey was completed on November 18, 2020. The complaint was unsubstantiated (intake #NC00169556). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This Statement of Deficiencies was amended on December 4, 2020, due to additional information received which necessitated further investigation. Rule 10A NCAC 27G .0202, Personnel Requirements (tag v108) is amended to a standard deficiency.	V 000	LIFE, Inc. will ensure all new and re-hired staff receive training upon hire or rehire to include client specific training for each individual in the home. Client specific training and all personnel requirements regarding training will be provided by the appropriate supervisor and documented. Documentation of the training will be maintained in the employees' training files. The assigned QP is responsible for ensuring the training is completed and documented as well as filed appropriately. The employee charts are to be reviewed every 6 months to ensure employee files are in compliance. Employee chart review for staff #1 completed August 2020 attached. Next chart review scheduled for February 2020.	1/28/21
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained	V 108	DHSR - Mental Health JAN 29 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristin P. Bowen MS QP II — TITLE: Program Manager — (X6) DATE: 1/28/21

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
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V 108	Continued From page 1 to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 3 audited staff (#4) received training to meet the needs of the clients. The findings are: Review on 12/03/20 of staff #4's record revealed: - Title of Direct Care Professional, hire date 7/27/18. - Client specific training regarding clients #2, #4 and #5 completed 7/31/18. - No evidence of updated client specific training. During interview on 12/03/20 staff #4 stated: - She had completed client specific training for the facility clients. - She returned to work at the facility in October 2020. - She worked as a "rotator" and was at the facility overnight. During interviews on 12/03/20 and 12/04/20 the Qualified Professional stated: - Staff #4 was hired by the Licensee and worked	V 108	In-service for client specific trainings as well as cap compentencies for each individual in the home has been completed placed in staff training file. (attached)	1/28/21

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
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V 108	Continued From page 2 briefly at the facility in 2018. - Staff #4 transferred to work at another of the Licensee's facilities and returned "about a month or so ago" to work as a "rotator"; staff #4 worked 7 days on and 7 days off. - Staff #4's client specific training was updated when she returned to the facility, but she was unable to locate documentation of the updated training.	V 108		

LIFE, INC EMPLOYEE CHART REVIEW

REVIEWED BY: Trinette Bowser
EMPLOYEE: Colleeshia Peek
DATE REVIEWED: 8/19/2020
HIRE DATE: 7/27/2018

I.	EMPLOYEE TRAINING FILE	YES	NO	N/A
1.	HAS THE GENERAL ORIENTATION FORM BEEN COMPLETED	1		
2.	IS THERE A CURRENT NCI TRAINING CERTIFICATE FOUND IN THE FILE	1		
3.	IS THERE A CURRENT CPR CERTIFICATE / CARD	1		
4.	IS THERE A CURRENT FIRST AID TRAINING CARD	1		
5.	IS THERE A CURRENT BLOOD BORNE PATHOGENS EXAM	1		
6.	IS THERE A MEDICATION ADMINISTRATION CERTIFICATE (IF APPLICABLE) AND RENEWED ANNUALLY		1	
7.	IS THE STAFF CREDENTIALS COMPLETED AND SIGNED BY ALL STAFF	1		
8.	IS THE PRIVILEGING FORM COMPLETED AND SIGNED BY ALL STAFF	1		
9.	IS THE EMPLOYEE PRIVILIGED FOR THE SERVICE PROVIDED	1		
10.	THERE IS A CURRENT SUPERVISION CONTRACT IN PLACE UPON HIRE AND REVIEWED ANNUALLY	1		
11.	THERE ARE SUPERVISION LOGS COMPLETED QUARTERLY FOR ALL STAFF		1	
12.	CAP CORE COMPETENCY TRAINING HAS BEEN COMPLETED PRIOR TO PROVIDING CAP/MR/DD SERVICES	1		
13.	THE HIPAA CONFIDENTIALITY AGREEMENT IS SIGNED BY THE EMPLOYEE	1		
14.	IS THERE EVIDENCE OF ON GOING TRAININGS?	1		
15.	HAS THE STAFF COMPLETED THE REQUIRED SERVICE TRAININGS?	1		
	PERSON CENTERED THINKING (ALL STAFF) Date:			
	PERSON CENTERED PLANNING (DD TCM) Date:			
	FIRST RESPONDER - CRISIS PLANNING (ALL STAFF) Date:			
	TCM ADDITIONAL 11 HOURS OF TRAINING Date:			
16.	IS THERE A CONSUMER WELL-BEING EXAM DONE IN JANUARY AND JULY	1		
17.	IS THERE A HAZARDOUS COMMUNICATION EXAM COMPLETED ANNUALLY			1
18.	IS THERE A FIRE SAFETY TRAINING EXAM FOR ALL RESIDENTIAL STAFF COMPLETED ANNUALLY	1		
19.	IS THERE AN EXAM FOR THE EMERGENCY RESPONSE PLAN COMPLETED ANNUALLY	1		
20.	IS THERE AN EXAM FOR INCIDENT REPORTING COMPLETED ANNUALLY	1		
21.	HAS PROOF OF ALL TRAININGS BEEN SENT TO HUMAN RESOURCES	1		

II.	EMPLOYEE MEDICAL FILE	YES	NO	N/A
1.	HAS A MEDICAL /TUBERCULOSIS FORM BEEN COMPLETED (1ST DAY OF EMPLOYMENT & ANNUALLY)	1		
2.	IS THERE EVIDENCE OF DRUG TESTS (RANDOM WITHIN 90 DAYS AND POST ACCIDENT)	1		
3.	IS THE HEPATITIS B VACCINE ACCEPTANCE/REFUSAL FORM COMPLETED	1		
4.	IS THE HEPATITIS B VACCINE RECORD COMPLETED (IF ACCEPTED BY EMPLOYEE)	1		
5	HAS A TB TEST BEEN FURNISHED OR PERFORMED AT TIME OF EMPLOYMENT	1		
6	IS THERE A COPY OF ANY ACCIDENT REPORTED ON THE ACCIDENT/INCIDENT REPORT FORM	1		
7	DO ALL ACCIDENTS INVOLVING A STAFF PERSON SEEN BY PHYSICIAN HAVE A COMPLETED	1		
	WORKERS COMP FORM (AUTHORIZED WITHIN 72 HOURS)			
8	ARE ALL PHYSICIANS NOTES LOCATED IN THE FILE	1		
9	IS THERE A SIGNED RELEASE TO RETURN TO WORK FROM THE ATTENDING PHYSICIAN	1		

LIFE, INC EMPLOYEE CHART REVIEW

III.	EMPLOYEE PERSONNEL FILE	YES	NO	N/A
1.	HAS AN APPLICATION BEEN COMPLETED	1		
2.	IS THE HEALTH CARE REGISTRY CHECK RECORDED AND FILED ANNUALLY	1		
3.	HAS A CURRENT JOB DESCRIPTION BEEN REVIEWED AND SIGNED UPON HIRE/CHANGE OF JOBS	1		
4.	HAS A PERFORMANCE EVALUATION BEEN COMPLETED ANNUALLY	1		
5.	IS A RESUME IN THE FILE (IF APPLICABLE)			1
6.	IS THERE A H.S. DIPLOMA/GED OR AN OFFICIAL H.S. TRANSCRIPT IN THE FILE	1		
7.	IS AN OFFICIAL COLLEGE TRANSCRIPT IN THE FILE FOR ALL QP OR TCM STAFF			1
8.	ARE THREE (3) REFERENCES IN THE FILE	1		
9.	HAS A COPY OF THE VALID N.C. DRIVERS LICENSE BEEN PROVIDED	1		
10.	IS THE INITIAL DMV CHECK IN THE FILE	1		
11.	HAS A COPY OF THE SOCIAL SECURITY CARD BEEN PROVIDED	1		
12.	IS THERE A COPY OF THE VALID AUTO LIABILITY INSURANCE		1	
13.	IS THERE A COPY OF THE CRIMINAL RECORDS CHECK	1		
14.	IS A COPY OF THE CONSUMER REPORTS RELEASE IN THE FILE	1		
15.	IS THERE A COPY OF THE W - 4	1		
16.	IS THERE A COPY OF THE NC - 4	1		
17.	IS THE PAYROLL TRANSMITTAL IN THE FILE	1		
18.	ARE EMPLOYEE LICENSES, CERTIFICATIONS IN FILE(IF APPLICABLE)			1
19.	ARE EMPLOYEE CEU'S IN THE FILE(IF APPLICABLE)			1
20.	IS THE FIRST AID/OSHA SUPPLIES SIGN OFF IN THE FILE (IF APPLICABLE)			1
21	FOR OVERNIGHT RESIDENTIAL STAFF, A TOUR OF DUTY AGREEMENT HAS BEEN SIGNED AND IS IN THE FILE	1		
22.	STAFF HAS SIGNED THE SIGNATURE FILE	1		
23.	RESIDENTIAL STAFF HAS SIGNED THE SHIFT AGREEMENT UPON HIRE AND ANNUALLY	1		
		44	3	47

TOTAL PERCENTAGE OF COMPLIANCE: 94

Corrections due by: _____

Corrections completed by: _____

QP signature: _____ Date: _____

PM signature: Justin D. Barrett Date: 8/19/20

QA/QI Director signature: _____ Date: _____

CAP-MR/DD CLIENT SPECIFIC COMPETENCIES

Consumer's Name: [redacted]

Before starting work:

Diagnosis/Needs 1/1/20

Approved Physical Interventions 1/1/20

Goals/Outcomes 1/1/20

Behavior Concerns 1/1/20

Communication Techniques 1/1/20

Medical Concerns 1/1/20
- ✓ Seizures
- ✓ Allergies
- ✓ Medications

Medication Administration 1/1/20

Assistance with Self-Medication Administration N/A

Routines 1/1/20
- Daily Care
- ✓ Use of Adaptive Equipment
- Transfers/Carries

Within 90 Days or as specified:
All competencies specified in the individual's plan of care.

_____ 1/1/

_____ 1/1/

_____ 1/1/

The signatures below verify that training in the elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.

Colleen Reik 1.28.21
Signature of Direct Care Staff Date

✓
Signature of trainer

1/28/21
Date

CAP-MR/DD CLIENT SPECIFIC COMPETENCIES

Consumer's Name: [redacted]

Before starting work:

Diagnosis/Needs 3/1/20

Approved Physical Interventions 3/1/20

Goals/Outcomes 3/1/20

Behavior Concerns 3/1/20

Communication Techniques 3/1/20

Medical Concerns 3/1/20
- ___ Seizures
- ✓ Allergies
- ✓ Medications

Medication Administration 3/1/20

Assistance with Self-Medication Administration N/A

Routines 3/1/20
- ✓ Daily Care
- ___ Use of Adaptive Equipment
- ___ Transfers/Carries

Within 90 days or as specified:
All competencies specified in the individual's plan of care.

_____ ___/___/___

_____ ___/___/___

_____ ___/___/___

The signatures below verify that training in the elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.

Chelsea Peck — Signature of Direct Care Staff — 1.28.21 — Date — ~ — Signature of trainer — 1-28-21 — Date

10/22/01

CAP-MR/DD CLIENT SPECIFIC COMPETENCIES

Consumer's Name: [redacted]

Before starting work:

Diagnosis/Needs 4/1/20

Approved Physical Interventions 4/1/20

Goals/Outcomes 4/1/20

Behavior Concerns 4/1/20

Communication Techniques 4/1/20

Medical Concerns 4/1/20
- Seizures
- Allergies
- Medications

Medication Administration 4/1/20

Assistance with Self-Medication Administration N/A

Routines 4/1/20
- Daily Care
- Use of Adaptive Equipment
- Transfers/Carries

Within 90 days or as specified:

All competencies specified in the individual's plan of care.

_____ __/__/__

_____ __/__/__

_____ __/__/__

The signatures below verify that training in the elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.

Colleen Reik 1.28.21 ✓ 4-1-20

Signature of Direct Care Staff Date Signature of trainer Date

10/22/01

Re: Complaint Survey completed 12/4/20
Roanoke Trail Facility
MHL#028-013

Dear Ms. Anderson,

Attached is the final plan of correction for the standard level deficiency cited during our compliant survey on December 4, 2020. Please advise if you need additional information.

Sincerely,

Trinette G. Bowser, MS QPII
Program Manager

801 Second St. • Elizabeth City, North Carolina 27909
Phone: (252) 338-3622 • Fax: (252) 338-3413