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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			71. 501251110.		F	₹		
MHL028-013		B. WING			12/20/2021			
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE				
ROANOKE TRAIL FACILITY 185 ROANOKE TRAIL MANTEO, NC 27954								
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE		
V 000	INITIAL COMMENTS		V 000					
	on December 20, 2	low up survey was completed 021. The complaint was the #NC00182998). A						
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.						
	The survey sample current clients.	consisted of audits of 4						
V 736	27G .0303(c) Facilit	ty and Grounds Maintenance	V 736					
	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.							
		on and interview the facility in a safe, clean, and orderly						
	am and approximat - A broken window i sharp glass shards glass fragments on - A case of 96 rolls o boxes, approximate approximately 22 in	of toilet paper, 2 cardboard						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES ((X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
					_		
			D WING		R		
		MHL028-013	B. WING		12/2	0/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE			
TV AVIL OF I	NOVIDEN ON OUT LIEN						
ROANO	KE TRAIL FACILITY		NOKE TRAIL				
		MANTEO,	NC 27954				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
				DEI IOIENOT)			
V 736	Continued From page 1		V 736				
	-						
	water bottles stored	I in the dining room.					
	- Unpainted repairs	to the ceiling between the					
	living room and the	dining room.					
		the bottom of the upright					
	freezer.	1 3					
	- The finish on the l	kitchen cabinets was worn.					
		n the floor in client #4's					
	bedroom.						
	- Client #4's dresser was missing 3 drawer pulls.						
	- Organic debris in the window sill of client #4's						
	bedroom window.						
	- Client #4's closet walls were discolored and						
	scuffed.						
	- Boxes of clothing and papers on the floor in						
	client #5's bedroom.						
		appeared consistent with mold					
	or mildew around the windows in the front door. - A pine sapling growing in the gutter above the front porch. - A wooden swing discarded by the trees at the						
	end of the driveway.						
	,						
	During interview on 12/20/21 the Qualified						
	Professional stated:						
	 Client #2 broke the dining room window on 12/15/21. She submitted a work order to have the window repaired on 12/16/21. 						
		not responded to the work					
	order.	not responded to the work					
		how long it would take for					
		air the broken window.					
	ппанненаное ю тер	all the bloken willuow.					
	During interview as	12/20/21 the Program					
		12/20/21 the Program					
	Manager stated:	analism bus disent #O diseits of					
		proken by client #2 during a					
	behavioral episode						
		already cracked, also by client					
	#2.						
	- She would submit	a work order to have the					

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 2 of 3 Z7JE11

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Division of Health Service Regulation

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					F	R		
MHL028-013			B. WING 12/20/2021			0/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 185 ROANOKE TRAIL								
ROANOKE TRAIL FACILITY MANTEO, NC 27954								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 736	Continued From page 2		V 736					
	window repaired.							
	This deficiency con and must be correc	stitutes a re-cited deficiency sted within 30 days.						

Division of Health Service Regulation STATE FORM