

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2024
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NAME OF PROVIDER OR SUPPLIER ROANOKE TRAIL FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 185 ROANOKE TRAIL MANTEO, NC 27954
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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
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on February 1, 2024. 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 Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 291	<p>27G .5603 Supervised Living - Operations</p> <p>10A NCAC 27G .5603 OPERATIONS</p> <p>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.</p> <p>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.</p> <p>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.</p>	V 291	<p style="text-align: center;">RECEIVED FEB 19 2024 DHSR-MH Licensure Sect</p>	

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

Debra J. ... B1911

TITLE

Program Manager

(X6) DATE

2/12/2024

Division of Health Service Regulation

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V 291	<p>Continued From page 1</p> <p>Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#5). The findings are:</p> <p>Review on 02/01/24 of client #5's record revealed: - 31 year old female. - Admission date of 09/01/23. - Diagnoses of Moderate Intellectual Developmental Disability, Generalized Anxiety Disorder, Obsessive Compulsive Disorder and Tourette's Syndrome. - No documentation client #5's blood pressure (BP) or pulse rate was checked.</p> <p>Review on 02/01/24 of a signed physician order for client #5 dated 09/01/23 revealed: - "Admit to Life Inc. Roanoke Trail DDA (Developmentally Disabled Adults) home. All orders good for 90 days...Check blood pressure and pulse monthly - Notify nurse if BP over 150/100 or less than 90/60 or if pulse over 120 or less than 50...."</p> <p>Review on 02/01/24 of client #5's Medication Administration Records (MAR) from October 2023 thru January 2024 revealed: - No documentation client #5's BP and pulse had been checked per doctor order on 09/01/23.</p>	V 291	<p>To be in compliance with rules, Life, Inc. will employ the following:</p> <p>#1 Director of Nursing for [REDACTED] discontinued order to have blood pressure and pulse checked monthly. Client #5 receives medical services by a physician in the community and will determine if these checks are required for her care.</p> <p>#2 [REDACTED] will not utilize standard admission forms when an individual receives medical services by a community provider. Orders will be obtained by the community provider. All physician orders will be entered into the Medication Administration Record as ordered by each client's physician.</p>	<p>2/9/2024</p> <p>2/9/2024</p>
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V 291	Continued From page 2 Interview on 02/01/24 the Habilitation Coordinator stated: - Client #5 was readmitted to the facility in 2023. - The staff check all the client's weights monthly. - Staff would not have checked client #5's BP and pulse since it was not on the MAR. - She alerted the nurse of client #5's physician order dated 09/01/23 for review.	V 291 #3	[REDACTED] P and Habilitation Coordinator will ensure all vital checks are completed as ordered by physicians and recorded in client records.	2/9/2024
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LIFE, Inc.
STAFF INSERVICE REPORT

Date: 2/8/2024

Instructor's Printed Name: Debra J. Provencher, BA QPII

Time Length of Break: _____

Instructor's Signature: *Debra J. Provencher*

Inservice Begin Time: _____

Inservice End Time: _____

- * Topic Covered: Habilitation Coordinator and Qualified Professional will complete routine audits of client Medication Administration
- * Topic Covered: Records to ensure documentation of all medications and vital signs to include BP, Pulse, etc. are completed as ordered by client physicians.
- * Topic Covered: _____
- * Topic Covered: _____
- * Topic Covered: _____
- * Topic Covered: _____

- Expiration Date: _____
- Expiration Date: _____
- Expiration Date: _____
- Expiration Date: _____
- Expiration Date: _____
- Expiration Date: _____

EMPLOYEE'S PRINTED NAME (Please print clearly)	EMP ID #	Is this Employee a NEW HIRE?	EMPLOYEE'S SIGNATURE (Please sign legibly)	FACILITY #	ARRIVAL TIME	DEPARTURE TIME	COMPONENTS	PASS/FAIL
[REDACTED]	[REDACTED]	N	[REDACTED]	241				
[REDACTED]	[REDACTED]	N	[REDACTED]	272				