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 _____	08/19/2025

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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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E 006	Continued From page 1	E 006		

Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.
(2) Include strategies for addressing emergency events identified by the risk assessment.
This STANDARD is not met as evidenced by:
Based on policy review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment utilizing an all-hazards approach. The finding is:

Review on 8/19/25 of the facility's current EP plan revised on 9/25/24 revealed the community and facility-basked risk assessment was last updated on 10/18/18.

Interview on 8/21/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed she did not have any other material for the community and facility-based risk assessment for the EP.

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W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct a fire drill on each shift and for every quarter. The finding is: Record review on 8/19/25 of the fire drills conducted between September 2024-August 2025 revealed there were missing drills on 3rd shift between October 2024 to June 2025. Interview on 8/19/25 with the Home Manager revealed she was hired in February 2025 and started to conduct drills in March, 2025. The Home Manager acknowledged she was not familiar with the requirements for the fire drills. Interview on 8/19/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they have had several Home Managers working in the home and there was a gap in time before the current Home Manager started working. The QIDP acknowledged that some of the drills were likely not done on 3rd shift.	W 440		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 4 audit clients (#6) ate in a manner which was not stigmatizing. The finding is: During dinner observations in the home on	W 488		

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W 488	Continued From page 3 8/18/25 at 5:45pm, the Qualified Intellectual Disabilities Professional (QIDP) and Staff B alternated feeding client #6 his meal. Client #6 wore a clothing protector around his neck, with the bottom of it placed under the plate. There was food debris on the clothing protector that rested on the table. Review on 8/19/25 of client #6's Individual Program Plan (IPP) from 11/14/24 revealed he utilized a clothing protector while eating and also have a high sided plate to decrease spillage. Interview on 8/19/25 with the QIDP acknowledge the staff starting to place the plate on top of the table, under his plate, because he had a habit of attempting to eat any food that fell and they did not want him to lose anymore weight. In public settings, the QIDP acknowledged they do not use a clothing protector because it would draw attention to him and if he spilled food on his clothes, they carried an extra shirt to change for him.	W 488		