Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

(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 and follow up survey was completed on May 26, 2023. The complaints were substantiated (intake #NC00201021 and intake #NC00201270). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier. This Statement of Deficiencies was amended on May 26, 2023 based on additional information received. Rule 10A NCAC 27D .0304 Protection from Abuse, Neglect, Exploitation or Harm (V512) was amended.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a	V 112	DHSR - Mental Health JUN 27 2023 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 112	Continued From page 1 projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the individual needs for 1 of 1 Former Client (FC #1). The findings are: Review on 4/24/23 of FC #1's record revealed: -An admission date of 12/29/22 -Diagnoses of Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder, Unspecified, and Child or Adolescent Antisocial Behaviors -Age: 15 -An assessment dated 11/21/22 noted "needs individual counseling, placement at a residential level III, has to continue to learn new coping skills to prepare him for interactions with peers, has to be prepared to make positive decisions in daily	V 112	CORRECTION IN PLACE WITH RESPECT TO ISSUES IDENTIFIED IN V112: i. The kitchen refrigerator lock has been removed. ii. AWOL, Suicidal and substance use goals have been added to client #1 PCP. iii. AWOL and DJJ goals updated on PCP. PREVENTION: i. QP, AP and HM will notify LP immediately of incident that occurred at the home for LP to update PCP ii. Monthly management meeting is conducted and matters pertaining to LWH regarding staff and employees are discussed and treatment goals will be updated accordingly by the LP iii. Monthly CFTS are held and treatment plans will be updated by LP accordingly. WHO WILL MONITOR: i. The QP and LP will review PCP monthly to make sure they are updated accordingly.	

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V 112	Continued From page 2 interactions with peers and has to continue to learn peer mediation, has to avoid influences by family member and peers, has multiple legal charges pending and needed emergency placement to remove him for a juvenile detention center, previously resided at the detention center for approximately 3 months, has a history of going AWOL (Absent Without Leave) and of being hospitalized. Additionally, it has been reported that the client has a history of physical and verbal aggression, is currently in the custody of DSS (Department of Social Services) but his mother is involved in his treatment." -A treatment plan dated 12/29/22 noted "will work on gaining independence by gaining employment, learning how to budget, opening up a bank account and other things to help him progress as a young adult, will attend school on a daily basis and participate in transition skills, complete assigned class work, ask for help as needed and follow the expectations and rules in the classroom by maintaining passing grades and daily attendance, will get a healthy amount of sleep and rest each night by going to bed on time, being quiet after lights out and going to sleep or resting quietly throughout the night, will not exhibit any incidents of inappropriate behaviors, will learn to communicate effectively with peers and adults by adopting effective coping strategies to asset him in managing behaviors, process feelings with adults, reduce the occurrences of displaying inappropriate anger, communicate effectively, be honest and open about his needs without lying and being manipulative and will utilize all coping skills, will working on building positive friendships with peers who can encourage and support him, will learn coping skills to process grief and support through the healing process." -Treatment recommendations included "be placed in a level III group home to provide him	V 112		

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V 112	Continued From page 3 with more stability and to ensure that he maintains the safety of himself and others. This placement will provide him with structure 24/7 with rules, routine, structure and will provide psycho-educational interventions based on group-based activities and additional therapy. He and his family need to take part in Family Centered Treatment to increase his ability to cope with environmental stressors, increase natural and community resources and improve functioning and communication with his family system, needs to continue to have his medications managed and monitored by his psychotropic medication management prescriber." -A detention order, dated 10/20/22 noted " ...must abide by the following terms and conditions during the pre-adjudication release period ...remain on good behavior and violate no local, state or federal law, not violate any reasonable and lawful rules of the juvenile's placements, report to a court counselor, cooperate with treatment ..." -No goals or strategies to address elopement tendencies -No goals or strategies to address following the Department of Juvenile Justice (DJJ)'s court order Review on 4/24/23 of the facility's communication and service notes log revealed: -2/5/23 "...first room checks were done around 9:45pm. All consumers were in their rooms/beds at this time. At 10:35pm, I did room checks again. [FC #1] was not in his room...911 was called and a missing person report was filed...around 12:25am, [FC #1] returned by ringing the doorbell..." -Undated note for 3rd shift revealed "[FC #1] MIA (Missing in Action). He went AWOL last night and	V 112		

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V 112	Continued From page 4 has not returned..." -2/17/23 "...Around 8:30pm, [FC #1] returned from being AWOL for 3 days ..." Review on 4/24/23 of the facility's incident reports revealed: -An incident report dated 2/15/23 at 11am noted FC #1 "Asked staff if he could make mop water to continue cleaning his room and was given permission...he bent down and put a note in the door and dropped the bucket and ran ...he went towards [a local road] and staff spotted him in a housing neighborhood and called 911..." Interview on 5/1/23 with the Qualified Professional #1 (QP #1) revealed: -Assisted the Licensed Professional (LP) with writing the goals and strategies for the clients' treatment plans -Had not updated FC #1's treatment plan on his elopement tendencies -Was aware FC #1 was on juvenile probation -Had not updated FC #1's treatment plan to follow the DJJ's court order Interview on 4/24/23 with the Licensed Professional (LP) revealed: -Worked with QP #1 to update treatment plans as needed -Had not updated FC's #1's treatment plan Interview on 4/30/23 with the Qualified Professional #2/Doctor of Nursing Practice/Licensee (QP #2/DNP/L) revealed: -Was aware FC #1's treatment plan was to be updated to address his elopement tendencies and following the DJJ's court order -"I will tell you this. From your investigation, I am learning a lot of what has not happened. It is my responsibility (to ensure the clients' treatment	V 112		

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V 112	Continued From page 5 plans were updated)... Apparently, [House Manager (HM)] did not contact the LP and complete the treatment plans ...if the goals and strategies are not there, then it was not done ..." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by:	V 512		

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V 512	Continued From page 6 Based on record reviews and interviews, 1 of 2 Former Staff (FS #1), 2 of 3 current paraprofessionals (Staff #2 and the Team Lead (TL)) and 1 of 2 Qualified Professionals (Qualified Professional #2/Doctor of Nursing Practice/Licensee (QP #2/DNP/L)) failed to protect 1 of 1 Former Client (FC #1) and 2 of 2 current clients (client #2, and client #3) from neglect and 1 of 3 current paraprofessionals (the House Manager (HM)) exploited 1 of 2 current clients (client #2). The findings are: Review on 4/24/23 of FS #1's record revealed: -A hire date of 1/7/23 -A job description of Direct Care Staff -A separation date of 4/18/23 Review of staff #2's record revealed: -A hire date of 11/1/21 -A job description of Direct Care Staff Review on 4/24/23 of the TL's record revealed: -A hire date of 2/1/23 -A job description of TL Review on 4/24/23 of the HM's record revealed: -A hire date of 1/2/21 -A job description of HM Review on 4/24/23 of the QP#2/DNP/L's record revealed: -A hire date of 1/25/21 -A job description of Licensee - Qualifications to meet the QP status Review on 4/24/23 of FC #1's record revealed: -An admission date of 12/29/22 -Diagnoses of Unspecified Trauma and Stressor Related Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Unspecified, and Child or	V 512		

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V 512	Continued From page 7 Adolescent Antisocial Behaviors -Age: 15 Review on 4/26/23 of client #2's record revealed: -An admission date of 12/12/22 -Diagnoses of Post-Traumatic Stress Disorder (PTSD), Oppositional Defiant Disorder (ODD) and ADHD -Age: 15 Review on 4/24/23 of client 3's record revealed: -An admission date of 4/12/23 -Diagnoses of Disruptive Mood Dysregulation Disorder, ADHD, Conduct Disorder, Unspecified, Major Depressive Order with Psychotic Features, Generalized Anxiety Disorder and PTSD -Age 17 Review on 4/24/23 of A4's record revealed: -An admission date of 12/29/22 -Diagnoses of Unspecified Trauma and Stressor Related Disorder, ADHD, Unspecified, and Child or Adolescent Antisocial Behaviors -Age: 15 Review on 4/26/23 of client A5's record revealed: -An admission date of 12/14/21 -Diagnoses of Major Depressive Disorder, Single Episode with Anxious Distress, Disruptive Mood Disorder, ADHD, and Central Auditory Processing Disorder -Age 17 Finding #1 Review on 4/26/23 of the facility's communication log revealed: -"On 4/5/23, second shift, ...[HM] and [QP #2/DNP/L] arrived on site to have a meeting with [FC#1] and [client #2] ...[FC#1] left with [HM] to go to the other home (sister facility A)..."	V 512		

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V 512	Continued From page 8 Review on 4/26/23 of the facility's internal investigation dated 4/5/23 revealed: -"Allegation of [FC #1] and [client #2] having sex. [FC #1] confided in a staff (FS #1) and told her that he and [client #2] had sex while at the group home. [FS #1] called and made the [HM] aware on 4/4/23 of this allegation. [FC #1] indicated that they were playing the game truth or dare. The truth part of the game got boring, so they began to dare each other. An emergency meeting was called on 4/5/23 between [QP #2/DNP/L], [HM], [FC #1], [client #2] and [staff #2]. [FC #1] expressed that this incident happened a while back (no clarity on exactly when). It is guessed to be a month prior to. [FC #1] stated [client #2] dared him to suck his toe, then suck he ear, then suck his nipple and eventually [FC #1] ended up giving [client #2] oral sex. He initially stated he was forced to 'suck his p***s'. [FC #1] appeared to be shaken and stated he didn't feel safe and didn't want to be in the same space as [client #2] anymore. [FC #1] also made staff aware that [client #2] beat him up so that he would keep quiet about it." Review on 4/26/23, of the facility's in-house report dated 4/6/23 revealed: -"A follow up meeting occurred on 4/6/23 which included [QP#2/DNP/L], [TL], [HM] [FC #1] and [client #2]. -Summary of evidence that confirms or denies allegation: [FC #1] recanted his initial statement that he was forced (to have sex). It was consensual sex between him and [client #2]. [Client #2] did not deny that something happened, however he was not specific as to what happened sexually between him and [FC #1] ...recommended actions for employer to take: [FC #1] from the facility to a sister facility for safety	V 512		

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V 512	Continued From page 9 ...actual actions taken by employer: [FC #1] is no longer in the same home as [client #2] ...date investigation was closed: 4/6/23." Review on 4/26/23 of the facility's level I in-house incident report dated 4/19/23 at 5:55pm and completed by QP#2/DNP/L revealed: -"On the evening of 4/10/23, at 6:00pm, [FS #1] contacted the [HM] and made her aware that [FC#1] confided in her that there had been sexual activity between him and another consumer at the group home (client #2). [QP#2/DNP/L] and [HM] went to the group home (4/10/23) to confront the consumer and in the interim, the consumer denied the allegation and within minutes changed his story and stated he was afraid because he was beat up by the consumer to keep quiet about it. The next day (4/11/23) we met again with [HM] and [TL] where the consumer in question (FC #1) was able to explain what happened and [FC #1] recanted his statement and stated that it was consensual sex. For the safety of both consumers, the clinical team (the Licensed Professional, the QP #2/DNP/L and Qualified Professional #1) advised us to separate the two consumers ...so it was determined [FC #1] would be a better fit in another facility...this was discussed during his Child and Family Team meeting (4/11/23) also ...we (the clinical team) separated the living situations of the consumers (client #2 and FC#1) to ensure safety ...our in-house investigation was conducted and completed with the conclusion of [FC #1] being moved to [sister facility A]." Interview on 4/24/23 with FC #1 revealed: -Admitted he played truth or dare with client #2 -Was unable to recall the date he played the game with client #2 -"When we played it, it led up to us having anal	V 512		

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V 512	Continued From page 10 intercourse and I sucked his p***s. He did not like that, so he beat me up in the closet ..." -Staff were downstairs when the sexualized behaviors occurred -"I later told [FS #1] about what happened. I told her not to say anything to anyone." -Had talked to the QP#2/DNP/L about the sexualized behaviors with client #2 -"I told her I did not feel safe, so she moved me to the other facility." Interview on 4/24/23 with client #2 revealed: -"[FC #1] was transferred to another facility because he made a sexual abuse allegation against me. We used to share a room (at this facility). That room is upstairs." -Admitted to getting into a physical altercation with FC #1 "because he told something I told him not to tell. I don't remember what it was though." -Admitted to playing a truth or dare game with FC #1 on one occasion -"We were awake one night and I did not feel like playing truth or dare because I was sleepy ...he started asking weird questions. Questions that were sexual. I told him I was not going for that. I put him in the closet and punched him. This was after the staff had done their bed checks." -Was not sure how often the facility staff conducted bed checks -FC #1 was close to FS #1 and "talked to her all the time." -"[FS #1] told me [FC #1] liked me and I said 'oh, h**l no.' I don't go for that." -Denied having any sexualized behaviors towards FC #1 -"I don't go for things with dudes. When he made that allegation to staff about me, I wanted to break his face open ...I am just waiting for the truth to come out, so he can look stupid ..."	V 512		

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V 512	Continued From page 11 Interview on 4/27/23 with FS #1 revealed: -Had previously worked 2nd shift, from 4pm to 11pm, at the facility -Due to elopement issues and the need for more supervision, FC #1 was moved upstairs to share a room with client #2 -On an unknown date, FC #1 confided in FS #1 he was "raped" by client #2 during a game of truth or dare -"I did not report it right away. I was not sure how [client #2] would react once he was made aware of the allegation ..." -Decided to report the sexualized behaviors between client #2 and FC #1 several weeks later, "because I was tired of [FC #1] going into details about what happened ..." -"I don't remember the date but maybe some time in March (2023), I told [TL] about it. He said he would tell [HM] and that she would get to the bottom of it. Nothing happened until April (2023), when [FC #1] was moved to another facility ..." -Stated she sat at the top of the stairs to supervise client #2 and FC #1 on her shift -Had not documented she supervised the clients by sitting outside their bedrooms. Interview on 4/24/23 with the TL revealed: -On 4/11/23, FS #1 made him aware FC #1 had alleged he was "raped" by client #2 -"Apparently, [FC #1] confided in [FS #1] about what occurred. I had worked 2nd shift at the facility with [FS #1]. She told me she had a conversation with [FC #1] and that he was infatuated with [client #2]...I then told [HM] and [QP#2/DNP/L] ...we had a meeting on 4/12/23 with the two clients, me, [QP#2/DNP/L] and [HM] ...it was decided [FC #1] would move to the other facility to keep him separated and safe from [client #2]." -"In my opinion, it (truth or dare) was a game that	V 512		

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V 512	Continued From page 12 went too far. And where it went, I am not sure ...a lot of time has gone by since it happened. I am not sure what provoked [FC #1] to say something. But when he did, the flood gates just opened, and everything came out ..." -"The initial allegation was [FC #1] was "raped" by [client #2]. There was no date as to when it occurred. [FS #1] told me she had known about the sexualized behaviors for some time. I asked her why she did not tell me. [FS #1] stated 'I was not working for the agency' when she learned of what happened. I do know it was not recent ..." -"When I talked with [HM] about it, she was saying it was all consensual. We are trying to find out if [FC #1] was harmed and we need to protect him ..." -Facility staff conducted bed checks every 30 minutes -Was not aware FS #1 had sat at the top of the stairs, outside client #2 and FC #1's bedroom to supervise them on her shift Interview on 4/28/23 with the HM revealed: -"[FC #1] made the allegation that [client #2] forced him to suck his p***s. All of this stemmed from them playing truth or dare...I do not know the date that this happened. It is my understanding the truth part got boring. At some point there were dares that were sexual in nature ...like suck my toe, suck my nipple and then it ended with oral sex. That is what [FC #1] said. [Client #2] denied anything happening ...I learned of the allegation towards the end of March (2023) and going into April (2023) ...we had a meeting at the office and present was me, [QP#2/DNP/L), [TL] and both of the clients. After the meeting we separated them and [FC #1] was transferred to another facility ...I think the incident happened several months ago." -Did not know why the two clients were not	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	05/26/2023

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V 512	Continued From page 13 separated immediately -"This all came out when [FC #1] confided in [FS #1]. She did not tell us about it until much later. I heard that [FS #1] told [TL] and he did not tell anyone about it. I don't know why he did not address it ..." -Was told by FS #1 that sexualized behaviors had occurred between the two clients (client #2 and FC #1) -"I went straight to [QP#2/DNP/L] and talked to her about it. I thought it was consensual sex between them." -Staff were to document the bed checks every 15 minutes Interview on 4/25/23 with the QP #2/DNP/L revealed: -Learned FS #1 knew about the sexualized behaviors between client #2 and FC #1 for several weeks and did not report it -" ...As soon as I learned of the incident, I called [HM]. I believe this was in March (2023). I went immediately to the facility. I sat down with [HM], [client #2] and [FC #1]. [HM] looked into the issue and stated since it was consensual, we could close out our investigation..." -Terminated FS #1 on 4/18/23 -"She was the one that [FC #1] told about the sexualized behavior and she held onto that information for a while. I don't know when the incident occurred between the clients, but we learned about it on either the 4th or 5th of April (2023) ...when I learned about the incident, I called [HM] and she told me she already knew about it. She said she was made aware of the sexualized behaviors on Sunday, the 2nd of April (2023) ..." Finding #2 Review on 4/26/23 of the facility's internal	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 14 investigation, dated 4/18/23 and completed by the QP #2/DNP/L, revealed: -An investigation began on 4/18/23 and concluded on 4/20/23 -Description of the allegation: "On 4/12/23 (there was a discrepancy with this date and the date the clients and staff stated they went on a therapeutic trip to the beach), staff (staff #2, the TL and the HM) and consumers (clients #1, #2, #3, clientA4 and client A5) went on a therapeutic trip to [a beach] to return on 4/15/23. On 4/13/23, staff (staff 2, the TL and the HM) and consumers (clients #1, #2, #3, clientA4 and client A5) stated after they returned from the amusement park, at approximately 10pm, [client #2] was seen walking into [HM]'s room and stayed in there for approximately 2 hours. One of the other consumers, [FC #1], also went into the room where he stated he saw [client #2] and [HM] laying in the bed. [FC #1] proceeds to tell [HM] good night and walked out of the room and left [client #2] and [HM] in the room. A few minutes later, [client #2] came out of the HM's room and was seen walking around the house. Then he (client #2) later proceeded back into [HM]'s room where he was in there for a few more hours. [Client #2] later left the HM's room and proceeded to tell one of the staff (TL) that he had just had an inappropriate sexual contact with [HM]. He later went back to the room. The other consumers and staff report he was seen entering [HM]'s room." -An initial meeting was held on 4/18/23 which included the QP#2/DNP/L, the Team Lead (TL), client #2 and staff #2 -A second meeting was held on 4/19/23 with the HM and QP#2/DNP/L, the TL and staff #2 and the following was concluded "all procedures were followed according to the policy written in the employment handbook."	V 512		

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V 512	Continued From page 15 -The HM was suspended (4/19/23) "pending the investigation, till further notice, leading up to termination (5/1/23)." -The investigation was concluded with the statement "inconclusive pending state investigation." Review on 4/26/23 of the facility's sleep logs from 4/13/23 to 4/14/23 revealed: -The checks by staff #2 and the TL occurred every 30 minutes -On 4/13/23 from 11:30 pm to 6 am clients #1, #2, #3, A4, A5 were documented as asleep by staff #2 -On 4/14/23 from 11:30 pm to 1:30 am client #2 was documented as awake by the TL -On 4/14/23 from 1:30 am to 6:00am client #2 was documented as asleep by the TL Review on 4/28/23 of a copy of the video taken by the HM and texted to surveyor #1 on 4/28/23, revealed: -No date or time of when the video was taken -The video was approximately 49 seconds long -The person that left a bedroom started to film video -The person headed down the hallway, turned right into the kitchen/living room area and scanned the living room -The video showed clients and staff asleep on the living room furniture -The first door to the left in the hallway was a bathroom -At the end of the hall was a bedroom with twin beds -In the twin beds, were client #3 and client A5 asleep -The first door to the right led into the kitchen/living room (open concept) -The living room had 2 sofas in an "L" shape, a	V 512		

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V 512	Continued From page 16 settee, a stool, and a television -The first sofa faced the large window -Client #2 was asleep on the first sofa -The second sofa faced the opposite wall and was pulled out into a double mattress -Asleep on the second sofa were client A4 and staff #2 -There were cushions that separated the two. -In front of the large window was the settee and stool -The TL was asleep on the settee -On the opposite wall of the second sofa, was a "pallet" on the floor -Asleep on the "pallet" was FC #1 -There was no air mattress on the floor in the living room. Interview on 4/24/23 with FC #1 revealed: -Told the QP #2/DNP/L about sexualized behaviors between him and client #2 prior to the beach trip -Went to the beach from 4/13/23 to 4/15/23 with client #2, client #3, client A4, client A5, staff #2, TL and HM -He "understood" from staff that the QP#2/DNP/L approved and paid for the beach trip -On the first night (4/13/23), he slept in the living room with staff #2, the TL, client #2 and client A4 -Was unable to recall if bed checks were conducted by the staff -"[HM] got suspended for having intercourse with a client. It was [client #2]. It is being investigated right now. I walked in and saw [HM] and [client #2] in bed together." Interview on 4/24/23 with client #2 revealed: -Went to the beach from 4/13/23 to 4/15/23 with FC #1, client #3, client A4, client A5, staff #2, the TL and the HM -On the second night of the beach trip (4/14/23),	V 512		

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V 512	Continued From page 17 "she (the HM) complained no one came to watch tv with her. I went in there and we watched [a movie title]. The door was closed. [FC #1] came in to get something. I guess [client A4] was following [FC #1]. They saw us on the bed." -"She (the HM) asked me if I wanted to have sex with her. I am not going to lie. I said 'yes'. She kept rubbing up against me. Her a*s cheeks rubbed up on the side of my leg and halfway up to where my private part was. She came onto me. She took her clothes off. We did missionary. And then we did doggystyle for a bit. I was supposed to sleep in the living room ... I was just shocked. In the moment , I think she took advantage of me. I am 15 years old, and she is like 48 years old ..." -"[Staff #2] and [TL] watched the other kids ...I came out of that room (the bedroom where the HM slept) about 2:01am." Interview on 4/25/23 with client #3 revealed: -"I am not involved in this, and I am not talking to you ma'am." Interview on 4/25/23 with client A4 revealed: -Went to the beach from 4/13/23 to 4/15/23 with FC #1, client #2, client 3, client A5, staff #2, TL and the HM -On the first night of the beach trip, client #2 slept in the living room with 2 staff (staff #2 and TL), FC #1 and client A4 -"On the second night (4/14/23), [client #2] slept in the same bed as [HM]. When [staff #2] went to do bedroom checks, [HM]'s bedroom door was closed. She (staff #2) opened the door and saw them (HM and client #2) in the same bed. Me and [FC #1] followed her (staff #2). I was behind [FC #1]. I saw them (the HM and client #2) laying on top of each other. [Client #2] was on top of [HM]. I think [staff #2] was suspicious that something was going on because [client #2] was in the	V 512		

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V 512	Continued From page 18 bedroom with [HM]. I was awake around 4am. [Client #2] came back to the living room and got on the couch." Interview on 4/25/23 with client A5 revealed: -Confirmed the beach trip occurred 4/13/23 to 4/15/23 with FC #1, client #2, client 3, client A4, staff #2, TL and the HM -"On the way back from the beach, I was in the van with [staff #2], [FC #1], [client #A4] and [TL]. [Staff #2], stated she walked into the master bedroom and saw [client #2] and [HM] in the same bed but with separate blankets. I think she was trying to make the assumption that something happened between them." Interview on 4/24/23 with staff #2 revealed: -Went to the beach on 4/13/23 with FC #1, client #2, client #3, client A4, client A5, TL and HM, and returned (to the facility) on 4/15/23 -The beach trip was planned by the HM and the QP#2/DNP/L paid for the beach trip -"We stayed in a condominium (condo) or apartment with two bedrooms and two baths." -The sleeping arrangements were planned before the beach trip occurred for FC #1 and client #2 to be kept separated -Client #3 and client A5 slept in one bedroom with separate twin beds -In the living room, FC #1 made a pallet on the floor with pillows, client #2 and A4 slept on the pullout couch -Staff #2 stated she made a pallet in front of the full couch where the TL was on the couch -The HM slept in the master bedroom where there was one bed -Client #2 was supposed to sleep on one of the two couches in the living room -An air mattress was brought to the condo to ensure everyone had separate sleeping	V 512		

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V 512	Continued From page 19 arrangements -"We (staff #2 and the TL) checked on them (the clients) every 15 minutes" -"Me and [TL] took turns sleeping." -"The first night (4/13/23), everyone slept where they were supposed to. The following night (4/14/23), I saw [client #2] missing from the couch around 1:00 am, and when I tried to open the door to the master bedroom, it was locked." -Believed client #2 was in the bedroom with the HM "because he was not in his designated sleeping place on the living room couch." -Did not see client #2 fall asleep on the couch (in the living room) -Told the TL that client #2 was not in his designated sleeping place -No one called the QP#2/DNP/L to let her know that client #2 was in the room with the HM -"I felt bad when it all came to light. What could I have done to make the situation better?" -The TL documented client #2 was not in his designated sleeping area -"[FC #1] told me when he walked into the master bedroom, he saw [client #2] and [HM] together with the TV on and [client #2]'s head laying on [HM]'s stomach." Interview on 4/28/23 with the HM revealed: -Since her suspension on 4/19/23, another allegation came up that she had sex with client #2 -"These kids will say anything. I would never do or say anything like that (the allegations)." -The HM stated she went on a beach trip on 4/13/23-4/15/23 with FC #1, client #2, client #3, client A4, client A5 and the trip was paid by the QP#2/DNP/L -In the van that the HM drove were FC #1, client A4, and client A5 -In the second van, driven by the TL were client #2 and client #3 and staff #2	V 512		

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V 512	Continued From page 20 -"Believed" the condo slept 6 people -"Everyone slept in the living room except for [client #3] and [client A5] who were in a bedroom in separate twin beds and she (HM) slept in the master bedroom." -She and staff #2 were supposed to have slept in the same bed but everyone was in the living room asleep the next morning (4/14/23) -In the living room, staff #2 slept on a pullout couch with client A4 with pillows between them for separation, FC #1 slept on a pallet on the floor, client #2 slept on another couch and the TL slept on a pallet on the floor near staff -Made a video of the sleeping arrangements of everyone which she provided for review -The video was made because she wanted to show QP#2/DNP/L that "the group home members were safe, altogether and were having a good time." -On Friday evening (4/14/23), the sleeping arrangements remained the same -Client #2 came into her bedroom (on 4/14/23) and watched tv because "he said he wanted to get away from [FC #1]." -While client #2 was in the HM's room, FC #1 came in and said "goodnight." -Had not documented any of her bed checks -Was supposed to be awake staff when all the clients were awake on the night of 4/14/23 but she was tired after they returned from being in the community and she went to sleep. -Initially stated she did not know why client #2 made the allegation and later stated "[FC #1] told lies and [client #2] had an upcoming court date and did not want me to testify." Interview with 4/24/23 with the TL revealed: -We went to a beach on Thursday, 4/13/23, and returned on 4/15/23 -The beach trip was planned prior to FC #1's	V 512		

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V 512	Continued From page 21 allegation (around 4/5/23) of being "raped" by client #2 -"[Client #2] came in and out of [HM]'s bedroom and into the living room three or four times. I redirected him to stay in the living room, but he went back to the bedroom. I told him several times to go lay down. He did not take my advice to go lay down. He went back in there (HM's bedroom). I am furious. Then I did not see him. [Client #2] disappeared. [Staff #2] went to track him down and the bedroom door was closed and locked. [Client #2] was in the room with [HM]. Then [FC #1] came to me and said, 'they are in there like mother and son.' It did not click with me. I wasn't thinking they were having sex. I said I would handle it. I did not go back there to check on him. Then it started to sink in. I became concerned. I did not know if I should have kicked the door down. I did not know how to protect him ...around 1:30 to 2:00 in the morning, [client #2] came back into the living room, got on the sofa and went to sleep." -Believed something transpired between client #2 and the HM -"What I do know is that [client #2] was in the room; [HM] was in the room and the door was closed. That is what I do know. It should have never gotten to this point. It may seem like we (the TL and staff #2) weren't doing our jobs, but [HM] did not do what she was supposed to do ..." Interview on 4/25/23 with the QP#2/DNP/L revealed: -Approved the beach trip from 4/13/23 to 4/15/23 for the clients and staff. -Made the decision to have the staff (#2, TL and HM) and the clients (FC #1, #2, #3, A4 and A5) stay in the 2 bedroom and 2-bathroom condo -Sleeping arrangements were made ahead of time by the HM to keep FC #1 and client #2	V 512		

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V 512	Continued From page 22 separated Interview on 5/3/23 with the QP#2/DNP/L further revealed: -Had partially discussed the sleeping arrangements for the beach trip with the HM -"She (HM) told me she would be in the living room with the other two staff (TL and staff #2). They even took an air mattress down. I did not discuss staff sleeping arrangements with her. She (HM) knew both of the bedrooms were to be occupied by the clients, except for [FC #1]. He would be sleeping on the air mattress in the living room. [Client #2] and [client A4] were to sleep in the same room (master bedroom with a queen bed), [client #3] and [client A5] would be in the other bedroom (guest bedroom with 2 twin beds) ...Apparently, when they all got there, no one wanted to be anywhere near [HM] (due to her attitude). None of them ..." -"The staff were to alternate doing bed checks." -"[Staff #2] made the decision to sleep in the same bed as [client A4]. When I talked to her about it, she said she did not want to be in the room with [HM] ...she said she thought it would be safe to sleep in the same bed since she had placed cushions in between her and [client A4] ..." -On 4/14/23, the HM sent a video (of clients and staff sleeping at the condo) to the QP #2/DNP/L via text message -"I did not see the video until 4/15/23 (The HM had texted her the video on 4/14/23 and the QP #2/DNP/L did not review the text message until 4/15/23). The video showed all the sleeping arrangements and showed [TL] and [staff #2] sleeping in the living room ..." -"[HM] was ultimately responsible for ensuring the sleep arrangements were followed and bed checks were done."	V 512		

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V 512	Continued From page 23 Review on 5/3/23 of the facility's Plan of Protection (POP), dated 5/3/23 and completed by the Licensed Professional (LP) and the Chief Financial Officer (CFO) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Lifeway Homes, LLC ("LWH") has terminated on May 1, 2023, the services of the House Manager who was in charge of making the report of the incident between the two consumers [client #2] and [FC #1], and who failed to report the incident. Additionally, LWH has separated the two consumers by moving [FC #1] away from the residence. We have also limited any type of one-on-one interactions between [client #2] and [FC #1]. Further, LWH will ensure that the staff is trained no later than May 10, 2023, to report and document all such incidents at the home. The documentation must then be provided to the QP to review and sign off on. The LP is aware of the allegations and will supervise the Plan of Protection. [LP] will then report to Management. Immediately (05/03/23), LWH through the LP will retrain all staff about abuse and neglect incidents, retrain them on reporting allegations of abuse and neglect; and retrain the staff on the levels of incidents and the time frame for reporting. LWH will retain staff on supervision policy no later than May 10, 2023. LWH will increase the frequency of bed checks to 15-minute interval, and the staff must put their names besides the slot, commencing on May 3, 2010. LWH will ensure that its LP is responsible for following the POP. -Describe your plans to make sure the above happens. On April 27, 2023, even prior to the issuance of this POP, LWH had a lengthy training with the staff and supervised by the LP. The training focused mainly on reporting and documenting incidents at the home. LWH will continue to train its staff to make sure we are in	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

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V 512	Continued From page 24 compliance with the rules and regulations, with the main goal being the safety and welfare of the consumers. The LP will ensure that all of this happens. None of the individuals cited is a part of the Plan of Protection. Additionally, as stated, LWH has separated the two consumers by moving [FC #1] away from the residence. We have also limited any type of one-on-one interactions between [client #2] and [FC #1]. Further, LWH will continue to ensure that the staff is trained to report and document all incidents of this type at the home. The documentation must then be provided to the QP to review and sign off on. [LP] will then report to Management. LWH will ensure that its LP is responsible for following the POP." Review on 5/26/23 of the facility's amended Plan of Protection, dated 5/26/23 and written by the CFO revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The underlying allegation stemmed from [HM] having an inappropriate sexual encounter with a consumer. The staff involved in the incident no longer works for Lifeway. We conducted a detailed investigation of the incident that happened at the beach between [client #2] and [HM]. We suspended [HM] without pay immediately on April 19, 2023, one day after we learned of the incident. We terminated our employment relationship with [HM] on May 1, 2023, when our own internal review found probably grounds that [HM] exploited the consumer. On May 3, 2023, [Licensed Professional (LP)] began the 'Abuse and Neglect Incident Reporting Training.' The first half was completed on May 3, 2023, and the final aspect was conducted today, May 17, 2023. LWH would add a new dimension to the training being done	V 512		

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V 512	Continued From page 25 by [LP] to focus on exploitation of consumers by May 31, 2023. We have also hired a new House Manager [HM's name] and we have begun training staff and continue to train staff, on how best to respond to serious incidents and resolve the immediate event/situation to prevent a recurrence of late reporting as we had the with the beach incident. We will ensure that the facility is staffed at all times in the ratio provided for in the regulations of two direct staff to every three consumers. We are training staff to ensure that the facts and circumstances of serious incidents are timely reported to us and that Management at Lifeway effectively reviews and investigates such incidents as required. The new [HM] will be in charge of staffing and making sure that we are in compliance with the ratio specified by law. We are training our staff to immediately request additional staff when people call in and failed to report for work. We have implemented in-house protocol to ensure that the recommendations for corrective actions discussed by the State/Agency officers who are conducting the investigations dealing with serious incidents in a timely and effectively implemented. [LP] has and will be in charge of training the staff. The House Manager will implement or carry out the enforcement part to make sure that the consumers are being supervised properly by the staff, with assistance of [QP #1]. The House Manager will make sure that the plan of protection is carried out. -Describe your plans to make sure the above happens. We reiterated that there must be at least two staff to every three consumers. We have implemented procedures to ensure that the children are being supervised at all times by the staff. We conduct bed checks on the consumers every 15 minutes. Our LP [LP's name] will be conducting additional training to ensure that the Qualified Professionals and Associate	V 512		

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V 512	Continued From page 26 Professionals are competent in what they do. We will also ensure that [LP] conducts additional trainings to ensure that our paraprofessionals are adequately supervised. The QP [QP #1] will assist the House Manager to ensure that the plan of protection is ultimately carried out." The facility served minor children with diagnoses not limited to: Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Child or Adolescent Antisocial Behaviors, Post-Traumatic Stress Disorder, and Unspecified Trauma and Stressor Related Disorder. FC #1 and client #2 engaged in alleged sexualized behavior. FC #1 disclosed this information to FS #1 on an unknown date. After she got tired of FC #1 talking about the behaviors, she then made the decision to inform the TL about FC #1's allegation of sexualized behaviors with client #2. When the TL failed to immediately report the sexualized behaviors, FS #1 told the HM. The HM became aware of the situation on April 2, 2023 and failed to report the information immediately to the QP #2/DNP/L. She informed the QP #2/DNP/L on either April 4th or April 5th, 2023 of the alleged sexualized behaviors. The HM thought the sexualized behaviors were consensual and did not immediately report the incident. The facility failed to put protective measures in place to address the allegation of sexualized behavior between the two clients when they became aware of the allegation. The QP #2/DNP/L approved and paid for 3 staff (staff #2, TL and HM) to take 5 clients on a beach trip from 4/13/23 to 4/15/23. This was after the allegation and investigation for sexualized behaviors between FC #1 and client #2. The QP#2/DNP/L did not ensure sufficient staffing for the clients to be supervised during awake and	V 512	**CORRECTION OF DEFICIENCY IDENIFIED IN V 512** I. Clients were immediately separately on the same day once QP was noticed of the incident. II. Incident reports were submitted once we were aware they were not submitted. III. Treatment plans were updated with sexualized behaviors. IV. Medical appoints were scheduled for all the consumers involved. V. HM was immediately suspended on her first day after returning to work and was later terminated. VI. Training was conducted by the LP on Abuse, neglect and exploitation. Incident reporting, staff supervision VII. Minimum staffing requirements has been implemented. VIII. Staff involved who didn't report the incidents immediately were written up IX. Bed check conducted every 15 mins **PREVENTION** i. In-service on incident reported was conducted by the LP on 5/8/2023 to all staff at LWH. Contents discussed are: Type of incidents to report, the level of incidents, when, how and to whom and where it should be reported. Who will be in charge of overseeing all incident (QP) and who to ask for. ii. There will be 2 staff to 1-4 consumers on every shift. Staff has been educated to report immediately if a staff doesn't show up for work and management will make certain of another staff to be present for work. iii. PCP will be updated monthly by QP and LP iv. Consumers have been referred for sexualized behavior therapy. v. Ongoing in service will be conducted on abuse, neglect and exploitation. vi. Bed checks every 15 mins **MONITOR** i. QP/AP shall monitor staffing schedule ii. QP//AP shall check all required documentation weekly to make sure staff is completing and performing their duties. iii. QP will review all incident reports with 24	

			hours of the incidents and do follow-up on incident reports accordingly and within the allocated timeframe to the different agencies. 24 hours, 72 hrs.	

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V 512	Continued From page 27 sleep hours while at the beach. On the second night of the beach trip, 4/14/23, the HM asked client #2 to come into the master bedroom of the condo to watch television. FC #1 went into the bedroom to say goodnight to the HM and observed client #2 and the HM under the covers in the master bedroom. FC #1 informed both staff #2 and the TL of his observations. Staff #2, followed by FC #1 and client A4, went to check on client #2. All three observed the HM and client #2 in the same bed. Staff #2 made the TL aware client #2 and the HM were in the bed together. Staff #2 and the TL failed to intervene to ensure the safety of client #2. The HM exploited client #2 while on the beach trip because she made the decision to be alone with client #2 in a bedroom with the door locked and closed. This led to client #2's allegation he had sex with the HM and his statement he was taken advantage of by the HM. This deficiency constitutes a Type A1 rule violation for serious neglect and exploitation and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		

6/20/23