Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL092-795		B. WING	B. WING		5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIFE SKI	LLS INDEPENDENT	CARF #1	RY HOWARD VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS	V 000			
	on 10/05/23. Deficie					
	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 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.					
V 293	27G .1701 Residen	itial Tx. Child/Adol - Scope	V 293			
	10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to					
	facilitate treatment;					

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		MHL092-795	B. WING		10/0	5/2023	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LIFE SKI	LLS INDEPENDENT (CARF #1	Y HOWARD VARINA, NC				
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V 293	(e) Services shall be (1) include instructure of daily liv (2) minimize related to functiona (3) ensure sa control behaviors in management with (4) assist the acquisition of adapt communication, so (5) support the gaining the skills not intensive treatment (f) The residential to shall coordinate with the structure of the struct	be designed to: dividualized supervision and ing; the occurrence of behaviors deficits; fety and deescalate out of cluding frequent crisis or without physical restraint; child or adolescent in the ive functioning in self-control, cial and recreational skills; and the child or adolescent in the eded to step-down to a less	V 293				
	failed to ensure ser	et as evidenced by: view and interview the facility vices were provided in the o current clients. (#1, #2). The					
	revealed: -Admission date of -Diagnoses of Oppo	0/3/23 of client #1's record 8/29/23 ositional Defiant Disorder I Anxiety, Adjustment Disorder					

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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		
	MHL092-795		B. WING		10/05/2023		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIFE SKI	LLS INDEPENDENT (CARE #1		Y HOWARD VARINA, NC			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 293	Continued From pa	ge 2		V 293			
	and Specific Learni	ng Disorder.					
	Record review on 1 revealed: -Admission date of -Diagnoses of Anxid Hyperactive Disord Interview on 9/28/2 -Stayed at the sister the weekends -Slept in an empty of -Client #2 went hon did not have enoug Interview on 9/28/2 - Stayed the night a and weekends because work 3rd shift Slept in an empty had one client there	10/3/23 ety, Attention er and ODD 3 client #1 star facilty in neiver facilty in the second at the second at the second at the sister or ause they dor bedroom, be	Deficit with ated: ighboring town on ister facility. ekends and they er both facilities. ated: in Wednesday in't have anyone cause they only				
	Interview on 10/3/23 the Qualified Professional sated: -Only had one client currently living in the sister facilityClient #1 went home every weekend, to either his therapeutic foster home or girlfriend's homeClient #2 stayed at the sister facilty on the weekendsHad two to three staff at sister facilty on the weekendsBeen having issues with staff shortage for several months.						
V 296	27G .1704 Resider Staffing	itial Tx. Child	/Adol - Min.	V 296			

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	MHL092-795		B. WING		10/0	5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		,
LIFE SK	ILLS INDEPENDENT (3ARE #1 800 PERR	Y HOWARD	ROAD		
	ELO INDEI ENDENT	FUQUAY \	/ARINA, NC	27526		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 296	Continued From pa	ge 3	V 296			
V 296	10A NCAC 27G .17 REQUIREMENTS (a) A qualified profetelephone or page. able to reach the fatimes. (b) The minimum required when child present and awake (1) two direct one, two, three or for (2) three direfor five, six, seven cadolescents; and (3) four direct nine, ten, eleven or adolescents. (c) The minimum reduring child or adolescents. (c) The minimum reduring child or adolescents. (c) The minimum reduring child or adolescents. (d) two direct and one shall be avechildren or adolesce (2) two direct and both shall be are children or adolesce (3) three direct of which two shall be assept for nine, ten adolescents. (d) In addition to the care staff set forth in Rule, more direct cathe facility based or individual needs as plan. (e) Each facility shasupervision of child	essional shall be available by A direct care staff shall be cility within 30 minutes at all number of direct care staff ren or adolescents are is as follows: care staff shall be present for our children or adolescents; ct care staff shall be present or eight children or a care staff shall be present for twelve children or sumber of direct care staff escent sleep hours is as care staff shall be present wake for one through four ents; care staff shall be present wake for five through eight	V 296			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL092-79	95	B. WING		10/	05/2023
	PROVIDER OR SUPPLIER	CARE #1	800 PERF	DRESS, CITY, S RY HOWARD VARINA, NC	-		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 296	Continued From pa child or adolescent needs as specified	s individual strer		V 296			
	This Rule is not me Based on interview failed to ensure a m staff wre present du two clients. The find Record review on 1 revealed: -Admission date of -Diagnoses of Oppo (ODD), Generalized and Specific Learni -Treatment plan da #1] can be transport to the home immediate control his opposition the community, starenvironment and for de-esculation." Record review on 1 revealed: -Admission date of -Diagnoses of Anxiolation date of -Diagnoses of Anxiolation date of -Treatment plan da #2] maybe transport appointments and sthe community."	and record revieninimum of two during transportation dings are: 0/3/23 of client # 8/29/23 Distributed 2/16/23 reveated 2/16/23 reveated safely and ifficately If consumer on all impulses. Iffication of the constant of th	w the facility lirect care on for two of 41's record Disorder ment Disorder aled, "[Client so, will return er cannot is staff is out in er in a safe or 42's record ficit with aled, "[Client to with aled,				

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	MHL092-795		B. WING		10/05/2023	
	PROVIDER OR SUPPLIER	CARF #1	DRESS, CITY, S Y HOWARD VARINA, NC			
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
V 296	Continued From pa	ge 5	V 296			
	in the morningsThe third shift staff mornings with no of Interview on 10/3/2 stated: -She had placed a gtreatment plan they staffClients were transpataffClients were also to in neighboring town-Will look at review	ted him and client #2 to school took them to school in the ther staff present. 3 the Qualified Professional goal in client #1 and client #2's could be transported with one ported to school daily by one transported to the sister facility by one staff. ng the treatment plan goal to supancy" and clients				
V 736	27G .0303(c) Facili	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.					
	failed to ensure the	et as evidenced by: on and interview the facility home was maintained in a active manner. The findings				
	Observation on 10/3/23 at 12:30 PM revealed the following: -Client #1 and #2's bathroom had a partially missing toilet paper holder where nails and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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LIFE SK	ILLS INDEPENDENT (CARF #1	RY HOWARD VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 736	bracket was expose nails and bracket sishower had missing be scraped off. -The siding on the land covered with a -The gutters and tritrees and limbs har -The back yard was high grass and tree Interview on 10/3/2 stated: -Not aware of the bathrooms. -Had rotted siding of the down spout not -Had someone to coback yard and was lawn mower, he would deficiency has	e, a broken towel rack with till in wall, and ceiling over g paint area and appeared to back and front door was rotted black tarp. m appeared to be rotted with nging down from them. sover grown with big bushes, elimbs. 3 the Qualified Professional roken items in client	V 736			

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