

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 10-5-23. The complaint was substantiated (#NC00205473). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for three and currently has a census of three. The survey sample consisted of audits of one current client and one former client.</p>	V 000		
V 293	<p><b>27G .1701 Residential Tx. Child/Adol - Scope</b></p> <p>10A NCAC 27G .1701 SCOPE</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to a community-based residential setting in order to facilitate treatment; and</p>	V 293		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 293	<p>Continued From page 1</p> <p>(2) treatment in a staff secure setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) include individualized supervision and structure of daily living;</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure coordination of care with other individuals and agencies within the child or adolescent's system of care. The findings are:</p> <p>Review on 8-8-23 of Former Client #1's record revealed: -Diagnoses include: Oppositional Defiance Disorder, Attention Deficit/Hyperactivity Disorder,</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 293	<p>Continued From page 2</p> <p>Unspecified Mood Disorder, Post traumatic Stress Disorder, and Conduct Disorder. -15 years old. -Comprehensive Clinical Assessment dated 10-31-22 revealed: Problems with defiance, coping skills, friendships, transitions and verbal and physical aggression. Last had Suicide Ideation 4-5 months ago. -Goals include participating in recreational therapy, participate in therapy to explore feeling suicidal and how to cope as evident by lifestyle changes, including managing stress, improving sleep, eating, and exercise habits, building a solid support network, and making time for hobbies and interests.</p> <p>Review on 8-10-23 of Incident report dated 7-18-23 revealed: - House manager was still in the office upstairs and after noticing there was no water running in the bathroom. The House Manager then went to check on [Former Client #1] and found that he wasn't in the bathroom. The House Manager went into [Former Client #1] room and found him in his closet hanging. The House Manager yelled for the QP ( Qualified Professional) and when seeing the state that [Former Client #1] was in. The House Manager and QP started CPR and called 911 for help. While waiting on 911 we were able to get a pulse from [Former Client #1] until 911 arrived. after 911 arrived they took [Former Client #1] to the hospital and asked staff questions about the incident that had happened. Police arrived at the home approximately 10 mins (minutes) after DCS (Direct Care Staff) called 911. The QP was on the phone with the director. When Medics arrived, DCS stopped performing CPR and medics took over. Medics proceeded to checking his vital signs and directors asked QP to ask about his</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 293	<p>Continued From page 3</p> <p>oxygen level which medics reported it was 97%. Medics placed him on, and an oxygen mask and [Former Client #1] was alert and responding to prompts from the emergency crew while being transported to the hospital. The police stayed behind..."</p> <p>Interview on 8-7-23 with Former Client #1's legal guardian revealed:                      -"The concern that I had, they didn't call the on call social worker. We found out the next day."                      -The guardian had been on vacation and the facility director had texted her about the incident.                      -Former Client #1 had paperwork explaining the people to call if she could not be reached.                      -No one from the facility went with Former Client #1 when he was taken to the hospital.                      -The hospital didn't know Former Client #1's name until the social worker told them the next day when she went to see him.                      -"He tried to take his own life, why wasn't someone from the group home with him."</p> <p>Interview on 8-8-23 with the facility manager revealed:                      -When they put Former Client #1 in the ambulance the night of the incident of 7-28-23, they gave information to the medic that was transporting him.                      -The police had told them that the facility was a crime scene and no one could leave.</p> <p>Interview on 8-11-23 with the Qualified Professional revealed                      -She was going to go to the hospital with Former Client #1 but "the police were nasty and rude to us."                      -The police has told them it was a crime scene and they had to stay at the facility.                      -Normally she would have gone to the</p>	V 293		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 293	Continued From page 4  hospital with the client. -The Director did reach out to the legal guardian, the Qualified Professional did not know how and did not know if the Director had talked to the legal guardian. -Former Client #1 called her the next day and told her that no one had given the hospital any information about him. -The medics had all the information and the facility had been told that a police officer would also be going to the hospital.  Interview on 10-5-23 with the Director revealed: -In the future they would ensure that someone either went to the hospital immediately, or very soon after to ensure that the client had been admitted properly and the hospital had all the needed information.	V 293		
V 367	27G .0604 Incident Reporting Requirements  10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 367	<p>Continued From page 5</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 367	<p>Continued From page 6</p> <p>.0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interviews the facility failed to all level II incidents were reported to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 8-4-23 of North Carolina Incident Response System (IRIS) revealed: -Incident with Former Client #1 attempted</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 367	<p>Continued From page 7</p> <p>suicide happened 7-18-23.</p> <p>-Incident submitted to IRIS 8-1-23.</p> <p>-Of note- Incident report was created on 7/18/2023 which is the day of the incident in the EHR system (THERAP) and was told by THERAP support staff that it was going to be submitted electronically to the IRIS system. A search of the IRIS system was not found by the LME, hence the director of [Licensee] was notified. The director then contacted THERAP and was told that in the state of North Carolina that the THERAP system was not connected to North Carolina which is why the LME could not find the report. This is the reason for the late entry in the IRIS system. Attached to this report is the original report on the day of the incident."</p> <p>-"[ Former Client #1] asked if he could finish folding and washing his clothes and to do his shower. [Former Client #1] stated that he needed some more detergent so that he could finish washing his last load of clothes. House manager went upstairs with [Former Client #1] the detergent out for [Former Client #1] to start his second load of laundry... asked if he could go ahead and take his shower. House manager was still in the office upstairs and after noticing there was no water running in the bathroom. The House Manager then went to check on [Former Client #1] and found that he wasn't in the bathroom. The House Manager went into [Former Client #1] room and found him in his closet hanging... The House Manager and QP started CPR and called 911 for help. While waiting on 911 we were able to get a pulse from [Former Client #1] until 911 arrived. after 911 arrived they took [Former Client #1] to the hospital and asked staff questions about the incident that had happened..."</p> <p>Review on 8-10-23 of undated and unsigned</p>	V 367		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 367	<p>Continued From page 8</p> <p>Suicide Safety Plan revealed: -Step 1: Warning signs: Situation: argument with a peer, confronted if have stolen, watch porn or lied, feeling of abandonment. Thoughts: "I am so fed up with this and I can't handle it anymore" Body sensations: Urge to vape, going to bed early. Behaviors: isolation, aggression, crying, argumentative. Being aware of his own warning signs can alert Gage to the fact that he may be at high risk of thinking about suicide when these situations/thoughts/body sensations arise. Gage can put the plan in action and move onto the next step: coping strategies. Being aware of personal warning signs can help staff identify when Gage may need more support, even before he asks for it." -Step 6: Making the environment safe: [Licensee] Homes staff shall ensure that all means have been removed from the home. Staff to always supervise him. Frequent checks (every 15 mins (minutes) bed checks and room checks) 2 times a week random room check/search. Leaving and entry consumer check. Environmental suicide precaution."</p> <p>Interview on 8-8-23 with the Facility Manager revealed -It was the Qualified Professional's responsibility to put incidents in the IRIS system. -The reason it was put in late was because they had recently switched to an electronic records system and were told it was directly linked to IRIS. -As soon as they found out that it wasn't, they submitted the report.</p> <p>Interview on 8-11-23 with the Qualified Professional revealed:</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601492</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/05/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE-WAY HOMES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7919 MOSSYCUP DRIVE</b> <b>CHARLOTTE, NC 28215</b>
--	---

(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 367	<p>Continued From page 9</p> <p>-"No it was not put in late. We did THERAP. We did not know then they did not know they did not do North Carolina. We had put it in. I can't remember when I put it in, but it wasn't put in late. We didn't know they didn't connect with IRIS. That's why we switched to THERAP. But that was something we were unaware of until [Executive Director] told us. We put it in on time."</p> <p>Interview on 10-5-23 with the Director revealed: -They now realized that THERAP was not connected to the IRIS system and that was now corrected going forward.</p> <p>This deficiency constitutes a recited deficiency and must be corrected within 30 days.</p>	V 367		