

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on June 3, 2024. The complaint was substantiated (intake #NC00216663). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		
V 294	<p>27G .1702 Residential Tx. Child/Adol -Req. for Q P</p> <p>10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS</p> <p>(a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience.</p> <p>(b) For each facility of five or less beds:</p> <p>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and</p> <p>(2) 70% of the time shall occur when children or adolescents are awake and present in the facility.</p> <p>(c) For each facility of six or more beds:</p> <p>(1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and</p> <p>(2) 70% of the time shall occur when</p>	V 294		

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: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 294	<p>Continued From page 1</p> <p>children or adolescents are awake and present in the facility.</p> <p>(d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include:</p> <ol style="list-style-type: none"> (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. <p>This Rule is not met as evidenced by: Based on interview and record review the person identified as the facility's Qualified Professional failed to meet the requirements of a Qualified Professional. The findings are:</p> <p>Review on 5/16/24 of the person identified as the facility's QP's personnel record revealed:</p> <ul style="list-style-type: none"> -Date of hire 7/19/23. -Job title QP. -Bachelor's Degree in mathematics in 1997 and a Master's Degree in education in 2011. -No documentation of at least 2 years of experience with the Mental Health/ 	V 294		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 294	Continued From page 2 Developmental Disability/ Substance Abuse population (MH/DD/SAS). Interview on 5/29/24 with the person identified as the facility's QP revealed: -No work experience with the MH/DD/SAS population. -The Licensee trained her on treatment plans and how to update treatment plans. Interview on 6/3/24 with the Licensee revealed: -Thought the QP's master's degree qualified her as a QP. -She (Licensee) had QP credentials. -She will act as the QP until she can hire a new one.	V 294		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 366	<p>Continued From page 3</p> <p>set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 366	<p>Continued From page 4</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 366	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies governing their response to Level II incidents. The findings are:</p> <p>Review on 5/9/24 of the facility's incident reports from 1/1/24 4 to 5/1/24 revealed: -Incomplete North Carolina Incident Response Improvement System (NC IRIS) reports for incident with Client #2 on 4/12/24. -On 4/12/24 Client #2 got a match and attempted to set fire to a lawn mower at the facility then ran away. -Incomplete NC IRIS report for incident with Client #2 on 4/25/24. -On 4/25/24 Client #2 left out of second floor window and did not return until hours later. -No documentation to determine the risk, cause and analysis of the incident on 4/12/24 when Client #2 attempted to set fire to a lawn mower and eloped. -No documentation to determine the risk, cause and analysis of the incident on 4/25/24 when Client #2 eloped. -No documentation of an assigned person to be responsible for the implementation or corrections and preventive measures. -No documentation of the cause of the incident, or recommendations for minimizing the occurrence of future incidents.</p> <p>Interview on 5/29/24 with the House Manager revealed: -The Licensee was responsible for submitting incident reports to NC IRIS.</p> <p>Interview on 5/29/24 with the person identified as</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 366	Continued From page 6 the facility's QP revealed: -"All direct care staff completed internal incident reports and submitted them to the [licensee]." -The Licensee was responsible for submitting incident reports to NC IRIS. Interview on 6/3/24 with the Licensee revealed: -Did not provide a risk cause analysis for incidents on 4/12/24 and 4/25/24. -"I notified the guardians and called the police." -"I entered the incident reports in IRIS, I wasn't aware that they didn't go through." -Would ensure submission of incident reports in NC IRIS going forward.	V 366		
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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident;	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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>(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 .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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>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"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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. <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of an incident. The findings are:</p> <p>Review on 5/10/24 of the NC IRIS revealed: -No incident reports for the facility from 1/1/24 to 5/1/24. -No incident report for the incident on 4/12/24 when Client #2 attempted to set fire to a lawn mower and eloped.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 incident report for the incident on 4/25/24 when Client #2 eloped.</p> <p>Interview on 5/29/24 with the House Manager revealed: -The Licensee was responsible for submitting incident reports to NC IRIS.</p> <p>Interview on 5/29/24 with Qualified Professional revealed: -All direct care staff completed internal incident reports and submitted them to the licensee. -The Licensee was responsible for submitting incident reports to NC IRIS.</p> <p>Interview on 6/3/24 with the Licensee revealed: -"I entered the incident reports in NC IRIS, I wasn't aware that they didn't go through." -Would ensure submission of incident reports and a risk cause analysis going forward.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 367		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 4/3/24 at 2:39 pm revealed:</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 736	<p>Continued From page 10</p> <ul style="list-style-type: none"> -The ceiling at the front door had two medium sized patched up holes. -The staircase wall had a large spot of chipped paint exposing the wood underneath. -Client #3's bedroom had 6 medium sized patched holes with spackle. -There was a 4 inch strip of wood with two screws in it preventing the window from opening in Client #3's bedroom. <p>Attempted interview on 5/28/24 with Client #1 and Client #2 but they declined.</p> <p>Interview on 5/28/24 with Client #3 revealed: -"I don't know who punched holes in the wall."</p> <p>Interview with on 4/3/24 with the Licensee revealed: -Not aware the strip of wood with two screws in it was preventing the window from opening. -"I didn't know that (strip of wood) was there. It's not supposed to be there."</p> <p>Review on 5/16/24 of the Plan of Protection dated 4/8/24 and signed by Licensee: "What immediate action will the facility take to ensure the safety of consumers in your care? The lock from the single window involved was immediately removed upon being notified.</p> <p>Describe your plans to make sure the above happens. After the lock was removed, the single window in question was able to open and close freely with sensor still intact and alarm was trigger with such action. Moving forward as a current policy in place within LWH, every month, we (all lifeway staff, supervised by the QP, Team lead, and AP) will continue checking all the windows within the facility and conduct a thorough window check to</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2024
--	---	---	---

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

(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 736	<p>Continued From page 11</p> <p>make sure;</p> <ol style="list-style-type: none"> 1. window sensors are still intact 2. no locks affix on the windows 3. Windows not tampered we have had consumers tampered with the windows and destroyed sensors. 4. lastly windows and doors checked are record by staff who conducted the checked and approved by either the team lead, QP or AP (Associate Professional). <p>In so doing, we are certain all the windows are in good working condition meaning they can open, close and alarm activated for the consumer and staff safety. The entire home is wired with an alarm system. During the check, we make sure the windows can open and close freely with no obstruction. If any obstruction noted, we would immediately address it. Lifeway last window and door check was conducted on 3/25/24, next check will be done on 4/29/2024 and will be documented as stipulated above. When the last check was conducted, none of the windows had locks. We also had a fire inspection, and no locks were on the window. In short, what was discovered as a locked window was an aberration, rather than normal."</p> <p>This facility served clients with diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Intermittent Explosive disorder and Conduct Disorder. Client #3's bedroom window would not open due to a 4 inch strip of wood with two screws in it preventing safe egress.</p> <p>This deficiency constitutes a Type A1 rule violation for neglect and must be corrected within 23 days.</p>	V 736		