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		
					F			
		MHL0601492	B. WING		09/1	0/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
LIFE-WAY HOMES, LLC 7919 MOSSYCUP DRIVE								
			TTE, NC 282					
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE		COMPLETE		
V 000	INITIAL COMMENTS		V 000					
	A follow up survey v 10, 2024. A deficier	vas completed on September acy was cited.						
		sed for the following service C 27G .1700 Residential cure for Children or						
	census of 3. The su	sed for 3 and currently has a urvey sample consisted of slient. This survey was new complaint.						
V 296	27G .1704 Residen Staffing	tial Tx. Child/Adol - Min.	V 296					
	REQUIREMENTS (a) A qualified profetelephone or page.	04 MINIMUM STAFFING essional shall be available by A direct care staff shall be cility within 30 minutes at all						
	(b) The minimum n required when child present and awake							
	one, two, three or for (2) three direction for five, six, seven of adolescents; and	-						
	nine, ten, eleven or adolescents.							
	during child or adole follows:	umber of direct care staff escent sleep hours is as						
		care staff shall be present vake for one through four ents;						

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			₹
		MHL0601492	B. WING		09/1	0/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIFE-WAY HOMES, LLC 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 296	(2) two direct and both shall be as children or adolesce (3) three direct of which two shall be asleep 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 shall supervision of child are away from the feetild or adolescent.	care staff shall be present wake for five through eight	V 296			
	failed to ensure the	et as evidenced by: on and interviews the facility minimum number of direct ent. The findings are:				
	Observation on 9/5/ the facility revealed -Only Staff #1 and 0					
	Interview on 9/5/24 -Worked first and so -He was the only sta -The second staff c	aff at the facility.				

Division of Health Service Regulation

STATE FORM 6899 T7LY11 If continuation sheet 2 of 3

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0601492	B. WING		F 09/1	R 0/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7919 MOSSYCUP DRIVE							
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 296	-"It's usually two pershifts were 7am-3pt 11pm-7amNotified the owner the beginning of his -The Owner made to Attempted interview revealed: -He declined interview school work online. Attempted interview #2, but there was no but did not receive a 9/10/24. Interview on 9/9/24	ople on every shift." om, 3pm-11pm and that Staff #2 had called out at shift. the schedule. on 9/5/24 with Client #1 ew because he was doing his on 9/5/24 an 9/6/24 with Staff or answer. A message was left a call back by the exit date with the Owner revealed: en advised there was only one edule. alled out.	V 296				

6899

Division of Health Service Regulation STATE FORM

T7LY11 If continuation sheet 3 of 3