STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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	Continued From page 39 Review on 1/11/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation of the incident report for cient #2 walking away from the facility on 12/18/23, being located by the police and transported to the local hosptial. Interview on 1/17/24 with client #2 revealed: -On 12/18/23 she ran from the group home. -She was found approximately a mile from her home by the police and was transported by ambulance to a local hospital. -She had been in the hospital since 12/18/23. Interview on 1/11/24 and 1/16/24 with the Owner/Qualified Professional (QP) revealed: -"[Client #2] walked off, so I'm teaching her a lesson." -The police brought client #2 back to the home and then was transported to the hospital by ambulance at the request of the Owner/QP. -Was responsible for completing incident reports. -No incident report was completed. -"I thought incident reports only needed to be done if someone got hurt or was transported to the hospital." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 367	Repeated Repeated RECEIVED MAR 11 2024 DHSR-MH Licensure Sect (facts but have since been informed differently) where can providers go for training when things like this happens to correct from happening again instead of being charged money?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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	Continued From page 38 .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: (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit a level II incident report 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 the incidents affecting 1 of 3 audited clients (#2). The findings are:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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	Continued From page 37 (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (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: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 36 Interview on 1/11/24 and 1/16/24 with the Owner/Qualified Professional (QP) revealed: -On 12/18/23, "[client #2] walked off, so I'm teaching her a lesson." -The police brought client #2 back to the home and then was transported to the hospital by ambulance at the request of the Owner/QP. -No documentation was available regarding the cause of the incident, corrective measures, measures to prevent similar incidents, and the person responsible for implementation of corrections and preventive measures. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	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:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 35 area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to level II incidents as required affecting 1 of 3 audited clients (#2). The findings are: Review on 1/11/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation of the incident report for client #2 walking away from the facility on 12/18/23, being located by the police and transported to the local hospital. Interview on 1/17/24 with client #2 revealed: -On 12/18/23 she ran from the group home. -She was found approximately a mile from her home by the police and was transported by ambulance to a local hospital. -She had been in the hospital since 12/18/23.	V 366	1/26/24 As stated in a previous statement. If IS Reports will be complete based on the issue at hand. I have since learned that if the police has to be called you should initate an IRIS Report. QP/manager will monitor when an issue arise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 34 (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (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: (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; (B) gather other information needed; (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 (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 (3) immediately notifying the following: (A) the LME responsible for the catchment	V 366	- there has not been any formal trainings for providers since the "connect the Dots" Training. which is very sad that providers have nothing to refer to but the rule book which has never been updated since I have been a provider. DHHS has not been to my facility in 3 1/2 years but never the less we are held accountable for compliance but don't provide NO Training to help stay in compliant when things Changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 33 (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 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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (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. (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: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy;	V 366	PCP has been update to show that all clients can. QP/Dona 1/26/24 will update accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 290	Continued From page 32 Interview on 1/23/24 and 1/25/24 with the Owner/QP revealed: -"I stay overnight...10 (pm) to 7(am) is third." -Clients rode the cab to and from the day program without staff supervision. "They have been doing that for years." -"They (clients) come back at 4 or 4:15 (pm) and then [staff #1] comes in. Sometimes I am there before they get there, and sometimes I don't get there until they come in the door. I don't have another person to come in. [Staff #1] can't stay overnight." -Staff #1 was scheduled to work from 5pm to 9pm. She worked other jobs and was not available 1st or 3rd shifts. -"They (clients) are left alone if I need to go somewhere to take care of business ... for like an hour or 2." -For 2 to 2 ½ weeks in December, while she was out of work, staff #1 covered all shifts. -"They (clients) are allowed to be there, according to their PCP (Person Centered Plan) they can be there 3 hours by themselves. It was in the old PCP that has been purged. I didn't update it in the PCP." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 290	the surveyor intentionaly told untruth things to guardian or shall I say a play on words to make her think that her Sister was not being monitered at all. If this was an issue w/ the Client riding the cab; I asked patricia the second ~~Surveyor~~ Surveyor why did she not state me on this when she came out - She looked like a deer in head lights and said I don't know why I did it maybe I missed it. I said well for 18 years all of you did because NO one has told me that.	
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 290	Continued From page 31 -"We get up at 5:30am. [Client #1] wakes us up." -"[Client #1] will give them (medications) to us when [the Owner/QP] is not there. [The Owner/QP] will have [client #1] give them." -"The cab picks us up at 6 or 7(am) for the program." -"We get home at 3(pm). Nobody is at the house. They put a key in the mailbox." Interview on 1/17/24 with client #3 revealed: -In the morning, "we wait on transportation - a cab." -"The cab brings us home (facility)" in the evening. -Denied being left at the facility without staff present. Observation on 1/24/24 at 10:30am revealed: -Key in the mailbox beside the front door. Interview on 1/18/24 with client #2's legal guardian revealed: -Was not aware of client #2 being left at the facility or in the community without staff supervision. -Client #2 "does not know how to be safe with traffic...She begs for money..." -Was not aware that client #2 was transported to and from the day program by a cab without staff present. "I think [the Owner/QP] picks them up." Interview on 1/19/24 with staff #1 revealed: -"I work 5pm to 8pm. When they (clients) get home at 4, they let me know. When I get off work (another job) I go straight to the house...Sometimes I leave at 8:30 or 9:00 (pm). When I leave they are on their own. I set out morning meds (on kitchen counter in cups with names on them) for them to take in the morning." -The clients "are pretty self-sufficient."	V 290	Again -Compulsive Liar -the Surveyor spoke w/ the guardian, stating that "was she aware that her sister #2 rides the cab alone?" Sister said it was my understanding that they all ride together (which they do."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 290	Continued From page 30 safe place to live with positive people that are supporting me" was working for client #2. -No documentation regarding client #2 being assessed to remain in the facility or community without supervision. Review on 1/11/24 and 1/16/24 of client #3's record revealed: -Admission date of 10/18/12. -Diagnoses of Mild IDD, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder. -Treatment plan dated 10/11/23 did not include documentation regarding being assessed to remain in the facility or community without supervision. Interview on 1/18/24 with client #1 revealed: -"Staff that works in the evening (staff #1) stays for a few hours then [the Owner/QP] comes in. Evening staff (#1) gets there around 5:30ish. She has a different job during the day." -The owner usually worked the overnight shift. -"I wake up everyone at 5:30am and do their hygiene-wash their face, help get them prepared." -"I fix breakfast. Sometimes [the Owner/QP] is too tired." -"Then we wait on transportation - a cab." -"We have a key that we leave in the mailbox. We come in (after attending the day program) and let [the Owner/QP] know we are home. Call her on the house phone. We get in the shower. Staff (#1) is at work, her other job. We get home by 4 or a little after. [Staff #1] gets there about an hour and a half later." Interview on 1/17/24 with client #2 revealed: -"She (the Owner/Qualified Professional (QP)) leaves [client# 1] in charge" when staff is not present. -Since her admission, "nobody stays at night."	V 290	I am not sure if this statement is true because she does not do anyone's hygiene but her own everyone is self sufficient to do their own ADL's. - this is a client who is discharged and a compulsive liar as stated by her guardian → over	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 290	Continued From page 29 duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure a minimum of one staff was present at all times except when the client's treatment or habilitation plan documented that the client was capable of remaining in the community or the facility without supervision affecting 3 of 3 audited clients (#1, #2, #3). The findings are: Review on 1/11/24 and 1/16/24 of client #1's record revealed: -Admission Date of 10/8/19. -Diagnoses of Mild Intellectual Developmental Disability (IDD), Schizophrenia, Autism. -Treatment plan dated 10/11/23 did not include documentation regarding being assessed to remain in the facility or community without supervision. Review on 1/11/24 and 1/16/24 of client #2's record revealed: -Admission date of 11/30/21. -Diagnoses of Major Depressive Disorder, IDD, Schizophrenia, Anemia, Pre-Diabetes, Seasonal Allergies, Obesity. -History of running away. -Treatment plan dated 1/10/23 included "Having a	V 290	States on the PCP the Client ~~can~~ can be unsupervisied in the community, Doctors appt & cab ride & the home. clients has proven they can. States on the PCP. QP/Owner will make sure PCP will be up dated accordingly. 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 290	Continued From page 28	V 290		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 131	Continued From page 27 Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 1 staff (#1). The findings are: Review on 1/11/24 and 1/15/24 of staff #1's personnel record revealed: -Hire date of 5/21. -No documentation of a HCPR check in the file. Interview on 1/19/24 with staff #1 revealed: -"I was hired in 2021. I'm not sure of the exact date. I left and came back in December (2023)...the first no the fourth. It was that Monday." Interview on 1/16/24 and 1/23/24 with the Owner/Qualified Professional (QP) revealed: -Was not sure of staff #1's hire date. "I would say April of 2021." -Staff #1 is not a rehire. "I use her every so often." -Prior to December 2023 she had not worked in about 4 months. -Did not have documentation of staff #1's HCPR check because the personnel file was missing after her recent move. -"I didn't do another (HCPR check) because it would show today's date."	V 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 118	Continued From page 26 -"They (clients) are pretty self sufficient to know not to take each other's pills." Interview on 1/12/24 and 1/23/24 with the Owner/QP revealed: -Was unable to locate documentation of staff #1's Medication Administration training due to her personnel file being misplaced during a recent move. -Was not aware that staff was punching out medications, leaving them in cups on the counter for the next morning, and documenting that she had administered the morning medications. -Staff #1 did not work 1st shift. -Was working with the pharmacy to get the missing medication orders. -Did not know why client #2's Atorvastatin was not documented as administered on 12/6/23, Aripiprazole was not documented as administered on 12/6/23 and 12/13/23, and Carbamazepine 8am dose was not documented as administered 11/5/23-11/30/23. -Had not obtained written authorization by the clients' physicians to self-administer medications. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 118	Complete	
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care	V 131	Complete on 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 118	Continued From page 25 Review on 1/16/24 of client #3's November and December 2023 MAR revealed: -Fluoxetine was documented as administered the entire month. -Fluoxetine was documented as administered at 8am by staff #1 for 11 days in December and by the Owner/QP the remaining days. -Loratadine was documented as administered at 8am by staff #1 for 12 days in December. Review on 1/15/24 of staff #1's personnel record revealed: -No documentation of Medication Administration Training. Interview on 1/18/24 with client #1 revealed: -"[Staff #1] asks which pills we take and we tell her." Interview on 1/17/24 with client #2 revealed: -"[Client #1] will give them (medications) to us when [the Owner/QP] is not there. [The Owner/QP] will have [client #1] give them." -"[The Owner/QP] leaves [client #1] in charge." -"[Client #1] does medicine at night and in the morning. Ever since I've been there." Interview on 1/17/24 with client #3 revealed: -Staff and the Owner/QP give medications. Interview on 1/19/24 with staff #1 revealed: -"I think I had it (Medication Administration Training)." -Gave clients 8pm medications (meds) when she worked. -"I pour morning meds in med cups and leave them on the counter. Their name is on there." -Signed the MAR indicating she administered the morning medication. -Did not work the morning shift.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 118	Continued From page 24 -Order dated 6/1/22 for Atorvastatin (cholesterol) 20mg take 1 tablet by mouth at bedtime. -Order dated 9/21/23 for Aripiprazole (Schizophrenia) 20mg take 1 tablet by mouth nightly. -No order for Carbamazepine (behavior) 200mg. Review on 1/16/24 of client #2's November and December 2023 MAR revealed: -Carbamazepine 8am dose was not documented as administered 11/5/23-11/31/23. 8pm dose was documented as administered the entire month. -Amlodipine Besylate was documented as administered at 8am by staff #1 for 6 days in December. -Carbamazepine was documented as administered at 8am and 8pm by staff #1 for 6 days in December and was administered by the Owner/Qualified Professional (QP) the remaining days. -Atorvastatin was documented as administered at 8pm by staff #1 for 6 days in December and was not documented as administered on 12/6/23. -Aripiprazole was documented as administered at 8pm by staff #1 for 6 days in December and was not documented as administered on 12/6/23 and 12/13/23. Review on 1/11/24 and 1/16/24 of client #3's record revealed: -Admission date of 10/18/12. -Diagnoses of Mild IDD, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder. Review on 1/16/24 of client #3's physician's orders revealed: -Order dated 1/9/24 Loratadine (allergies) 10mg take 1 tablet by mouth every day. -No Order for Fluoxetine (mood) 20mg.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 118	Continued From page 23 audited clients (#1, #2, #3). The findings are: Review on 1/11/24 and 1/16/24 of client #1's record revealed: -Admission Date of 10/8/19. -Diagnoses of Mild Intellectual Developmental Disability (IDD), Schizophrenia, Autism. Review on 1/16/24 of client #1's physician's orders revealed: -Order dated 10/31/23 for Ferrous Sulfate (nutritional supplement) 325 milligrams (mg) take 1 tablet by mouth every day before breakfast. -Order dated 10/27/22 for Polyethylene Glycol 3350 Powder (constipation) dissolve 17 grams mixed with 8 oz of water/juice and take by mouth every day. Review on 1/16/24 of client #1's December 2023 Medication Administration Record (MAR) revealed: -Ferrous Sulfate was documented as administered at 8am by staff #1 for 12 days in December. -Polyethylene Glycol 3350 Powder was documented as administered at 8am by staff #1 for 12 days in December. Review on 1/11/24 and 1/16/24 of client #2's record revealed: -Admission date of 11/30/21. -Diagnoses of Major Depressive Disorder, IDD, Schizophrenia, Anemia, Pre-Diabetes, Seasonal Allergies, Obesity. Review on 1/16/24 of client #2's physician's orders revealed: -Order dated 1/10/24 for Amlodipine Besylate (blood pressure) 2.5mg take 1 tablet by mouth daily.	V 118	Medications can be Self Administered by the Client. The QP/nurse will be responsible for making sure all orders are current & medications are not expired, however, that particular ~~That~~ OTC supplement was brought from the store during that year so it was expired when brought d.d not think to read the expiration date, will going forward. the QP/nurse will monitor before purchasing. 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 118	Continued From page 22 clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews the facility staff failed to ensure medications were administered to clients on the written order of a person authorized by law to prescribe drugs for 2 of 3 audited clients (#2 and #3), failed to ensure medications were administered by an unlicensed person trained by a registered nurse or pharmacist for 1 of 2 staff (#1), and self-administered by clients only when authorized in writing by the client's physician for 3 of 3	V 118	all orders has been updated by the pharmacy which was presented while the surveyor was there and I have an order from the Primary care the certain ← Sove	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 113	Continued From page 21 Interview on 1/19/24 with staff #1 revealed: -Documenting on the Medication Administration Record was the only routine documentation she completed. -"I talk to them (clients) about progress and go from there. It wouldn't be an everyday thing ...once a month." -Documentation of the clients' progress was not in the clients' records in the facility. -Kept documentation of progress with her. -Was unable to provide documentation of progress. Interview on 1/16/24 with the Owner/Qualified Professional (QP) revealed: -"Normally I put it (documentation of goal progress) on the PCP (Person Centered Plan)." -"I have a 6 month sheet I use on how things are going." -Did not provide any documentation of goal progress for the past year. -"I'm pretty sure I purged that file." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 113	True that was the conversation that we had and I was in the process of updating client records at the time. moving forward all client files will be updated accordingly by the QP 1/26/24	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 113	Continued From page 20 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to document the services provided and progress towards desired outcomes for 3 of 3 audited clients (#1, #2, #3). The findings are: Review on 1/11/24 and 1/16/24 of client #1's record revealed: -Treatment plan dated 10/11/23 "Long Range Outcome: [Client #1] wants to learn how to budget her money, work on her weight loss, continuing to learn how to cook, and learning more independent learning skills. Short Range Goal: [Client #1] wants to work on her social skills." -No documentation of services provided or progress toward outcomes. Review on 1/11/24 and 1/16/24 of client #2's record revealed: -Treatment plan dated 1/10/23 did not contain any goals or strategies for the residential setting. -No documentation of services provided or progress toward outcomes. Review on 1/11/24 and 1/16/24 of client #3's record revealed: -Treatment plan dated 10/11/23 "Long Range Outcome: [Client #3's] long range goal is to get her own place, go back to school, learn how to budget and also hygiene upkeep. Short Range Goal: To seek employment, budget money, weight loss and upkeep of hygiene." -No documentation of services provided or progress toward outcomes.	V 113	See page 18 for correction	1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 113	Continued From page 19 (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth, (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 112	Continued From page 18 Interview on 1/19/24 with staff #1 revealed: -Did not know any of client #2's goals. -"I haven't spoken to [client #2] about her goals." -"I didn't work on goals with [client #2] because the situation (being hospitalized) with [client #2] started the first two weeks after I started." Interview on 1/16/24 and 1/25/24 with Owner/QP revealed: -Was responsible for writing treatment plans. -Client #2's plan had expired because she was in the hospital. -Didn't think goals and strategies to address client #2's runaway behavior needed to be in the plan, because she hadn't run away since being at the facility. -Client #1 and Client #3 are their own guardians and should have signed their treatment plans. -"You can talk to them. They will tell you they participated." -Could not explain why strategies, interventions, service, and frequency were not included in client #1's and client #2's plans. -Helped clients with budgeting goals by calling the day program to find out "how they did shopping." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 112	Staff has been retrained on client goals and has ~~the~~ acknowledge that she knows & understands. the QP/owner will make sure that all staff members are trained and knowledgeable of each client goals Ect. Annually trainings. 1/26/24	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes:	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 112	Continued From page 17 -Did not include goals or strategies to address runaway behaviors. Review on 1/11/24 and 1/16/24 of client #3's record revealed: -Admission date of 10/18/12. -Diagnoses of Mild IDD, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder. -Treatment plan dated 10/11/23 was not signed by the client or the Owner/QP. -"Long Range Outcome: [Client #3's] long range goal is to get her own place, go back to school, learn how to budget and also hygiene upkeep." -"Short Range Goal: To seek employment, budget money, weight loss and upkeep of hygiene." -No service or frequency for the goal. -No strategies or interventions for the goal. Interview on 1/18/24 with client #1 revealed: -Had treatment team meeting last week (week of 1/7/24-1/13/24) with Staff #1 and Owner/Qualified Professional (QP). -"Most everything stayed the same." -Didn't have the ability to sign it because it was on the computer. Interview on 1/17/24 with client #2 revealed: -Wore a location tracking bracelet on her wrist because she has run away before. -Did not remember attending a treatment plan meeting. -"We don't talk about goals. [Owner/QP] don't talk about goals." -"I might have one (treatment plan)." Interview on 1/17/24 with client #3 revealed: -Had a treatment plan meeting on 1/11/24 with the Owner/QP. -Did not sign the plan.	V 112	all pcp's will be completed in its entirety 1/24/26 QP/owner will ensure that it is being done at the time of completion & Annually. Don't recall having or telling the Surveyor this although alot of things that was said was not being truthful	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 112	Continued From page 16 facility failed to obtain written consent or agreement by the client or responsible party for 2 of 3 audited clients (#1 and #3). The findings are: Review on 1/11/24 and 1/16/24 of client #1's record revealed: -Admission Date of 10/8/19. -Diagnoses of Mild Intellectual Developmental Disability (IDD), Schizophrenia, Autism. -Treatment plan dated 10/11/23 was not signed by the client or the Owner/Qualified Professional (QP). -" ...she (client #1) is weighing 274 as of 01/11/2024 ..." -"Long Range Outcome: [Client #1] wants to learn how to budget her money, work on her weight loss, continuing to learn how to cook, and learning more independent learning skills." -"Short Range Goal: [Client #1] wants to work on her social skills." -No strategies or interventions to indicate how client #1 is going to "work on social skills." -No short range goals, strategies or interventions to address cooking, weight loss, or budgeting. Review on 1/11/24 and 1/16/24 of client #2's record revealed: -Admission date of 11/30/21. -Diagnoses of Major Depressive Disorder, IDD, Schizophrenia, Anemia, Pre-Diabetes, Seasonal Allergies, Obesity. -History of running away. -Treatment plan signed by client #2's legal guardian dated 1/10/23. -"I would like to find employment." -Had never had stable housing. -Had been exploited by others in the past. -Needed to improve coping skills. -Did not contain any goals or strategies for the residential setting.	V 112	all pcp has been signed by each client and QP/owner. The QP/owner will make sure all pcp's are signed + dated on the day they are being completed 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 112	Continued From page 15 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 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 observations, record reviews and interviews, the facility failed to develop and implement goals and strategies in the treatment/habilitation plan to address the client's needs affecting 3 of 3 audited clients (#1, #2, #3). The facility failed to review the plan at least annually affecting 1 of 3 audited clients (#2). The	V 112	corrected all clients has a PCP wide make sure the are update Annually by Dana/QP. 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 14 Owner/QP was responsible for completing the QP duties in the facility. She did not follow admission and discharge policies for client #2 which resulted in client #2 being abandoned in the psychiatric holding area of the emergency department for over a month, and she did not meet criteria for hospitalization. An incident report and risk/cause/analysis was not completed when client #2 walked away from the home, was found a mile away and transported to the hospital. The Owner/QP did not train direct care staff on the specific needs of the clients. The Owner/QP did not develop and implement goals and strategies in the treatment plans to meet the needs of clients #1, #2, and #3. She did not obtain written consent for client #1's and client #3's plan and did not ensure client #2's plan was kept current. She did not ensure that progress toward goals were documented for all three clients, and there was no evidence that goals were being worked on. The owner/QP failed to ensure that medications were given on an order from a physician and that medications were administered by a trained staff member. Medications were left in cups on the counter overnight for the clients to self-administer in the morning. The clients had not been assessed and approved for self-administering by their physicians. The Owner/QP routinely left the clients unsupervised overnight, riding the cab to and from the day program, and in the afternoons. None of the clients had unsupervised time included as part of their plans.This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 13 QP I will have documentation of progress starting effective 1/26/24. 10A NCAC 27G Medication Requirements every new hire will go through the med (medication) training before he/she can pass meds all of the MARS will be checked over to make sure no holes are in the MARS (Medication Administration Records) and make sure all clients got their meds. Effective 1/21/24. 10A NCAC 27G Supervised Living for Adults the rule of my License is that a 5600C requires Supervision unless stated in their treatment plan. The Surveyor was given an updated treatment plan the speaks of the supervision in the home. Effective 1/21/24. 10A NCAC 27G .0603 Incident Response Requirement effective 1/26/24 I am aware as to when an IRS (Incident Response Improvement System) report should be submitted, in this case the client did not run away from the home. The surveyor did not speak w/ APS (Adult Protective Services) about what actually happen or did I tell her she ran away. 10A NCAC 27G .0604 Incident There was no Level II report made because the client did not run away nor did I tell her she did The Client walked out of the home because she could not have her way. Therefore the client did not want to comply w/ staff. Effective 1/26/2024. Describe your plans to make sure the above happens. Eff. (Effective) 1/26/24 A Plan of Correction will be done to make sure the above will be and has been in complient w/ the rules & regulations. I have provided documentation to show that the above events will not happen again." Four clients with diagnoses of Mild Intellectual Developmental Disability, Major Depressive Disorder, Schizophrenia, Obesity, Autism, Impulse Control Disorder, and Attention Deficit Hyperactivity Disorder reside in the facility. The	V 109		

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
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 12 maintaining documentation of services and progress toward goals, ensuring proper medication administration, scheduling staff and ensuring clients were supervised, and ensuring incidents were reported and ensuring a risk/cause/analysis was completed. Review on 1/26/24 of the Plan of Protection dated 1/26/24 written by the Owner/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 10A NCAC 27G .203- As the QP I will do progress notes on a monthly Basis to ensure clients goals are met also I will connect w/ (with) a person who has the same qualifications as a QP to look over my plan of correction to make sure I am in compliant. 1/26/24. 10A NCAC 27G .0201- my Discharge Policy was was correct [client #2] did not run away she left on her own accordance because she could not get her way. per my policy a client will be DC (discharged) if he/she decides they don't want to comply w/ house rules and causing problems for staff or clients. 1/26/24. 10A NCAC 27G .0202 Personnel Requirements I will maintain personnel files according to the rules at hand. As I stated to the Surveyor, the staff file was misplaced when I moved. All her required training was in her file along w/ the registry. I told the Surveyor it didn't make no sense for me to run another registry because the date will not be the same. I am will aware of the policy. Effective 1/21/24. 10A NCAC 27G .0205 Treatment Plan As the QP I will make sure that detailed documentation will be in their plan as far as supervision. I gave the Surveyor updated copies of the plan that is clear and detailed well and has been effective 1/21/24. 10A NCAC 27G .0206 Client Records As for new admission I will make sure that each client will have an admission date in their record. As the	V 109	Since then medication training has been given to staff prior to working w/ clients, proper documentation will be monitored by the QP/owner to ensure no holes are left in the MAR completed on 1/26/24 will make sure its done prior to hire. The QP will monitor to make sure	1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 11 Cross-Reference: 10A NCAC 27G .5602 Supervised Living for Adults with Mental Illness-Staff (V290). Based on record reviews, observations and interviews, the facility failed to ensure a minimum of one staff was present at all times except when the client's treatment or habilitation plan documented that the client was capable of remaining in the community or the facility without supervision affecting 3 of 3 audited clients (#1, #2, #3). Cross-Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interviews, the facility failed to implement written policies governing their response to incidents as required affecting 1 of 3 audited clients (#2). Cross-Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to submit a level II incident report 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 the incidents affecting 1 of 3 audited clients (#2). Review on 1/15/24 of the Owner/QP's personnel record revealed: -Hire date of 2004. -Position of the Owner/QP. Interview on 1/16/24 and 1/23/24 with the Owner/QP revealed: -Was responsible for the following duties: developing and implementing admission/ discharge policies, ensuring staff were trained, developing and implementing treatment plans,	V 109	PCP has been up date to reflect each client status w/o supervision QP/owner will monitor PCP Annually for Any changes. 1/26/24 Hrs reports are out or completed base on the rule that it is set forth in. I have since contacted Customer Service number ~~that~~ on the DHHS website to confirm and NO ~~other~~ one serves mecklenburg county to assist with Policy but go help from another person 1/26/24 2/1/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 10 Cross-Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record reviews and interviews, the facility failed to ensure 1 of 1 paraprofessional staff (#1) received training to meet the mental health/developmental disability/substance abuse needs of the clients as specified in the treatment/habilitation plans. Cross-Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on observations, record reviews and interviews, the facility failed to develop and implement goals and strategies in the treatment/habilitation plan to address the client's needs affecting 3 of 3 audited clients (#1, #2, #3). The facility failed to review the plan at least annually affecting 1 of 3 audited clients (#2). The facility failed to obtain written consent or agreement by the client or responsible party for 2 of 3 audited clients (#1 and #3). Cross-Reference: 10A NCAC 27G .0206 Client Records (V113). Based on record reviews and interviews, the facility staff failed to document the services provided and progress towards desired outcomes for 3 of 3 audited clients (#1, #2, #3). Cross-Reference: 10A NCAC 27G .0209 Medication Requirements (V118). Based on record reviews and interviews the facility staff failed to ensure medications were administered to clients on the written order of a person authorized by law to prescribe drugs for 2 of 3 audited clients (#2 and #3), failed to ensure medications were administered by an unlicensed person trained by a registered nurse or pharmacist for 1 of 2 staff (#1), and self-administered by clients only when authorized in writing by the client's physician for 3 of 3 audited clients (#1, #2, #3).	V 109	she was present in the home. One client was the only one who was d/c from the home that didn't have a written statement 1/26/24 or discharge. The owner QP will monitor the progs to make they are completed PCP will be completed on an annual basis by the QP/owner 1/26/24 I have A QP that was present at the documentation was not done. QP/owner has or will document on a monthly basis. 1/26/24 Orders was given by the pharmacy will the surveyor was still present and proof was given. I am aware that all medications that a client takes has to have an order by the doctor.	

Continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 109	Continued From page 9 (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 1 of 1 Qualified Professional (QP) (Owner/QP) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Cross-Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interviews, the facility failed to develop and implement written policies/procedures for admission and discharge.	V 109	I have a wr. Hen Policy & Procedure on Admission & discharge which was given to the Surveyor while	

Continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 108	Continued From page 8 Owner/Qualified Professional (QP) revealed: -Was not sure of staff #1's hire date. "I would say April of 2021." -Staff #1 is not a rehire. "I use her every so often." -Prior to December 2023 she had not worked in about 4 months. -Did not provide training to meet the mental health/developmental disability/substance abuse needs of the client. -"Why would I do a training on that?" -"Anyone (staff) coming in would do a new client orientation." -Could not provide documentation of new client orientation because staff #1's personnel file had been misplaced during a recent move. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 108	- Background Check was completed on which was presented to the surveyor. 5/21/2021 - NCI training 10/19/23 - Seizure Managment 10/20/23 - CPR/First Aid 10/20/23 - Bloodborne pathogens 10/20/23 The owner/QP/HP will monitor all New hire files on going to make sure they stay in Compliance.	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 108	Continued From page 7 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 paraprofessional staff (#1) received training to meet the mental health/developmental disability/substance abuse needs of the clients as specified in the treatment/habilitation plans. The findings are: Review on 1/11/24 and 1/15/24 of staff #1's personnel file revealed: -Hire date of 5/2021. -No documentation of completion of training to meet the mental health/developmental disability/substance abuse needs of the clients. Interview on 1/19/24 with staff #1 revealed: -"I was hired in 2021. I'm not sure of the exact date. I left and came back in December (2023) ...the first, no the fourth. It was that Monday." -Did not receive training to meet the mental health/developmental disability/substance abuse needs of the client. -Knew the clients, except for client #2, from working in the facility previously. -"I looked over [client #2's] file." -Did not know client #2's goals. -"I didn't work on goals with [client #2] because the situation (hospitalization) with [client #2] started the first two weeks after I started." Interview on 1/16/24 and 1/23/24 with the	V 108	training for the Staff member in question. I had another provider to sign off on the training and review the paper work that has been provided. Per the request of the Surveyor. The Staff Member has also Completed the Medication training w/ the Pharmacist 2/22/24 - The Staff Member has been trained on the New Client Orientation, Newline 1/26/24 - Client Rights orientation 1/26/24 - MRDD Training 2/1/24 - Abuse & Neglect 2/1/24 - the registry pulled again 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 6 she went in the hospital. That is her discharge date." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 and must be corrected within 23 days.	V 105	Corrected D/C letter completed	1/29/24
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108	the Staff File Was misplaced due to me moving to another location which I have all the Files with me @ home. Haever, each New hire does go through all the required training listed in 10A NCAC 27G .0202. One Step Forward will make Sure that all Staff Files are in compliant with the State regulations accordingly to the Rule. I Have completed another	

Continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 5 facility. She was quickly found, the same day, about a mile from the facility. -At the time of the interview, the Owner/QP had not told her that client #2 had been discharged from the facility. Interview on 1/23/24 with the Owner/QP revealed: -Client #2 had worn a "Safety Alert" bracelet for about a year. -The bracelet was a free program through the local police department used to locate people who wander. -12/18/23 is the only time client #2 walked away from this facility. -Client #2 had walked away from an unlicensed facility operated by the Owner/QP previously. -"When I noticed that she runs I moved her to this location (the facility)." -Client #2 had been at the current facility "about 6 months." -"The admission date on file is not when she moved to this facility it is when she started with me." -Did not complete an admission assessment when she moved to the facility. -Did not know the exact date client #2 moved into the facility. -"I told her (client #2's) sister (legal guardian) if she (client #2) leaves...it is dangerous and I'm going to discharge her." -Discharge policy says, "elopement risk is immediate discharge." Interview on 1/25/24 with the Owner/QP revealed: -Did not provide a copy of the admission policy. "You didn't ask for that. You asked for the discharge policy. You should have that (admission policy). I had to send that to the state for the license." -Discharge date for client #2 is "12/18/23 when	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 4 came out." -"She (the Owner/QP) said she couldn't have me endangering her group home." -The Owner/QP told her she would not be allowed to go on outings even though, "I never did run from an outing." Interview on 1/11/24 with the Owner/QP revealed: -Client #2 was in the hospital and had been there since 12/18/23 because she "walked off, so I am teaching her a lesson." -Was planning to pick client #2 up from the hospital to return to the facility later in the day. Interview on 1/12/24 with the Owner/QP revealed: -Upon hospital discharge on 1/11/24, "I got the meds (medications) and got to the hospital to pick her up. The lady (hospital staff) came out with discharge paperwork. She (client #2) got in the car and I told her we would have to put safety measures in place at home. She would be restricted from going on outings like the [local store]. She jumped out of the car and ran into the hospital." -Client #2's legal guardian "begged" her to take client #2 back because client #2 did not belong in the hospital and had nowhere else to go. -"I'm not willing to take her (client #2) back at this point. It will just be a headache for me. She is not going to do right." Interview on 1/18/24 with client #2"s Legal Guardian revealed: -Client #2 has a history of running away when she doesn't get her way. -Client #2 wears a tracking bracelet that she got from the local police department that will track her location when she walks away from staff. -The local police department was able to track client #2 through the bracelet when she left the	V 105	No wrong doing was done on my behalf. I have attached a copy of the paper work. QP/Owner will monitor how discharges will be processed ongoing and moving forward 1/26/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 3 escorted back to room 36, pt was discharged from here. Pt states that 'the lady from group home was mean to me.'" -Psychiatry note dated 1/15/24: Client #2 was "discharge ready." Interview on 1/12/24 with the Social Worker from the local hospital Emergency Department Behavioral Health Unit revealed: -Client #2 had been in the Emergency Department's Behavioral Health Unit since 12/18/23. -Client #2 had not met criteria for hospitalization and was being held there until a discharge placement could be found. -Client #2's legal guardian was unable to care for client #2. -On 1/11/24 the Owner/Qualified Professional (QP) arrived at the local hospital Emergency Department's Behavioral Health Unit unit to pick up client #2 to take her back to the facility. While in the car, the Owner/QP told client #2 there would be rules about outings. Client #2 became upset and ran back into the hospital. The Owner/QP left her at the hospital. Interview on 1/17/24 with client #2 revealed: -On 12/18/23 she ran from the group home. -On 12/18/23 she was found approximately a mile from her home by the police and was transported first to the facility and then, by ambulance to the local hospital Emergency Department Behavioral Health Unit. -"I wear this on my arm (bracelet). Police came by yesterday (1/16/24) to check it. It was set up by [Owner/QP] and my sister (legal guardian). It posed to track you down when you walk away." -On 1/11/24 the Owner/QP came to the hospital to take her back to the facility. "She (the Owner/QP) said people from protection services	V 105	there were rules put in place prior to Client #2 to return to the home & day program. As stated in the Summary of deficiencies that she would not be able to attend Outings per her guardian, the program and the home due to safety reasons which is leaving when she can not have her way. Client did not want to comply what was put in place for her and that was explained to the Surveyor during that time. APS report was filed From the hospital, APS has closed the case has found no fault against me. That	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement written policies/procedures for admission and discharge. The findings are: Review on 1/11/24 and 1/16/24 of client #2's record revealed: -Admission date of 11/30/21. -Diagnoses of Major Depressive Disorder, Intellectual Developmental Disability, Schizophrenia, Anemia, Pre-Diabetes, Seasonal Allergies, Obesity. -History of running away. -No discharge summary or date of discharge. Review on 1/25/24 of the facility's policy and procedure manual revealed: -Criteria for discharge: "If the client becomes unstable and or elopes from the home on his/her own." -No policy for admission. Review on 1/17/24 of client #2's records from the local hospital Emergency Department Behavioral Health Unit revealed: -Psychiatry note dated 12/19/23: Client #2 was "medically stable ...currently felt to be of low imminent risk of harm to self." -Physician note dated 1/11/24: "Pt (patient) (client #2) was just discharged from room36 on c side to group home. The person who picked her up and upset her so she got out of the car, and they will no longer take her back ...Here for recurrent placement. No other new concerns otherwise." -Nursing note dated 1/11/24: "Pt (client #2)	V 105	QM HP and one step forward will comply w/ Policy & Procedures that is set forth in the home policy & procedure Admission to complete a discharge for every Client(s) who is discharged from the home according the rules. NO staff member will be able to complete a discharge. only the QP and or Marsha will be able to complete that. if it occurrs again. Although Marsha who is the QP knew that it wasn't done, went back to pick up the client from the hospital w/ the approval from the guardian & hospital. the Client refuse to come back because She did NOT want to follow the Rules.	1/26/24

continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 An annual and follow up survey was completed on 1/26/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Marsha Adams TITLE Owner/AP (X6) DATE 2/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601060	A. BUILDING: _____ B. WING _____	R 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE STEP FORWARD OUTREACH	10000 WOODY RIDGE ROAD CHARLOTTE, NC 28273

(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 An annual and follow up survey was completed on 1/26/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

MECKLENBURG COUNTY
Department of Social Services
Services for Adults Division
PEOPLE • PRIDE • PROGRESS • PARTNERSHIPS

Kim Henderson
Department Director

Gregory Tanner
Division Director

January 29, 2024

Betty Tillman
200 Hawthorne Lane,
Charlotte, NC 28204

Ms. Tillman

This letter is to inform you that Mecklenburg County DSS is closing your Adult Protective Services case.

We found that you are **not** in need of protection at this time, and you have a support system in place to assist you with accessing community resources.

Thank you,

Durant Norton
Social Worker II- Adult Protective Services Unit
Mecklenburg County Department of Child, Family & Adult Services
Valerie C. Woodard Center-Chapin Hall
3205 Freedom Drive, Charlotte, NC 28208
Office: 980-314-7054 Work Cell: 704-936-9552