Division of Health Service Regulation STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

MHL0601553		B. WING		01/0	01/03/2025		
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE			
EXT LE\	/EL FAMILY SOLUTIONS	LLC	LDE ENGLISH OTTE, NC 282				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RRECTION	V (X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual and compla on 1-3-25. The compla (#NC0022359). Deficie	aint survey was completed aint was unsubstantiated encies were cited.					
	This facility is licensed	for the following service			-0		
	category: 10A NCAC 27G 5600B Supervised Living for Minors with a Developmental Disability.			RECEIV	ED		
	This facility is licensed	F 0 1 11 -1		JAN 137	2025		
	census of 2. The surve	for 3 cand currently has a sy sample consisted of		3/111	Sect		
	audits of 2 current clier	nts.		DHSR-MH Licens	Sule Scot		
V 114	27G .0207 Emergency	Plans and Supplies	V 114				
	10A NCAC 27G .0207 AND SUPPLIES	EMERGENCY PLANS					
	(a) Each facility shall dand a disaster plan and these plans available	evelop a written fire plan I shall make a copy of				4-	
		cy services agencies upon Il include evacuation		Fire and disaster drills will be conductione time per shift (weekdays 7am-3pm-11pm & 11pm-7am) and	om,	t	
	procedures and routes. (b) The plans shall be rand evacuation proceduposted in the	nade available to all staff ures and routes shall be		(weekends 7am-7pm & 7pm-7am) po NFLS will put in place a policy that fill drills are completed by the 25th of ea Fire and disaster drills will be review basis by QP and/or Director to ensu	re and disaster ach month.	3-3-25	
	facility. (c) Fire and disaster dri				or sempliance of po	noy.	
1	shall be held at least qu repeated for each shift.	***				1	
	simulate the facility's re-	d under conditions that sponse to fire					
	emergencies. (d) Each facility shall ha	ve a first aid kit					
	accessible for use.	TO A MOLAIC AIL					
of Health	n Service Regulation	PLIER REPRESENTATIVE'S SIGNATURE	1 10	0 0	,		

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 01/03/2025	
	MHL0601553		B. WING			
	PROVIDER OR SUPPLIER VEL FAMILY SOLUTIONS,	STATE, ZIP CODE DRIVE 16				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	1	V 114			
	failed to ensure that fir	is evidenced by: w and interview the facility e and disaster drills were on each shift. The findings				
	-During the week t 7am-3pm, 3pm-11pm,	th the Director revealed: there are three shifts, and 11pm-7am. the shifts were 7am-7pm				
	2024. -No fire drills on se third quarter of 2024. -No first or second quarter of 2024.	25 revealed: drill for the first quarter of econd or third shift for the shift fire drill for the fourth for the third or fourth				
	Clients #1 and #2 could both being non verbal.	not be interviewed due to		9		
× 1	Interview on 1-3-25 with -She would ensure drills would be complete appropriately.	that going forward, all				
V 513	27E .0101 Client Rights Alternative	- Least Restrictive	V 513			
	10A NCAC 27E .0101 ALTERNATIVE (a) Each facility shall pr	LEAST RESTRICTIVE ovide services/supports				

Division of Health Service Regulation

SN8W11

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED B. WING _ MHL0601553 01/03/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11128 OLDE ENGLISH DRIVE

NEXT LEVEL FAMILY SOLUTIONS, LLC

	CHARLO	OTTE, NC 2821	6	
(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 513	that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513	All locking systems have been removed from the refrigerator, drawers and cabinets. Ongoing supervision of this will be monitored by QP and/or Director.	3-3-25
r	This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the least restrictive and most appropriate setting effecting 2 of 2 clients (Client #1 and Client #2). The findings are: Review on 1-3-25 of Client #1's record revealed: -Admitted 2-9-2410 years oldDiagnoses of Down Syndrome and AutismNo documented reason for her having the refrigerator, kitchen cabinets, of her dresser drawers locked.			

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		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
ŀ		MHL0601553		B. WING			01/03/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11128 OLDE ENGLISH DRIVE CHARLOTTE, NC 28216								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
		Review on 1-3-25 of C -Admitted 8-12-24 -16 years oldDiagnoses of Aut Developmental Disabil -No documented r refrigerator and kitcher Observation on 1-3-25 revealed: -Refrigerator in the locking system on it an locked -Several cabinets i locking system on them -Client #1's bedroo plastic locking system of the dressers were locked Client #1 and Client #2 interviewed due to both Interview on 1-3-25 with -The locks were pla no longer lived at the fa -That client would a drawers and put the iter -That client would a cabinetsShe would make s	lient #2's record revealed: ism and Intellectual ity. eason for her having the cabinets locked. at approximately 1:00pm e kitchen with plastic d the refrigerator was In the kitchen had plastic and they were locked. In the drawers and both of ed. were unable to be clients being nonverbal. In the Director revealed: aced for another client that cility. cometimes empty her	V 513				

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