	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		MHL0601060	B. WING		R 06/12/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ONE STEE	P FORWARD OUTREACH		DY RIDGE RO	DAD	
CHARLOT			E, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow on 6/12/25. Deficienci	up survey was completed les were cited.			
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.			
	This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients.				
V 114	27G .0207 Emergenc	y Plans and Supplies	V 114		
	AND SUPPLIES (a) Each facility shall and a disaster plan ar these plans available to the county emerger request. The plans ship procedures and route (b) The plans shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least or repeated for each shift.	e made available to all staff dures and routes shall be drills in a 24-hour facility quarterly and shall be ft. ted under conditions that response to fire			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorace mon	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:	
		MHL0601060 B. WING		R 06/12/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ONE STE	P FORWARD OUTREACH	10000 WO	ODY RIDGE RO	DAD	
ONE STE	FORWARD OUTREACE	CHARLOT	TE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 114	Continued From page	e 1	V 114		
	This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have completed fire and disaster drills held at least quarterly and repeated on each shift. The findings are:				
	Review on 6/10/25 of the facility's fire and disaster drill log from June 1, 2024-May 1, 2025 revealed:				
	1st quarter (January- March 2025): - No 1st shift (4pm-10pm) and 2nd shift (10pm-7am) disaster drills.				
	3rd quarter (July- Sep - No 1st and 2nd shift	•			
	4th quarter (October- - No 1st and 2nd shift	•			
		ith Client #1 revealed: disaster drills monthly.			
		ith Client #2 revealed: disaster drills monthly.			
	Interview on 6/11/25 with Client #3 revealed: - Completed fire and disaster drills monthly.				
		with Staff #1 revealed: disaster drills monthly.			
	Professional revealed - Changed the routine being completed after home for annual visit; - "I had records comp Fire Chief stated that	e of fire and disaster drills r the Fire Chief came to the			

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STATE FORM 6899 4ALM11 If continuation sheet 2 of 9

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL0601060	B. WING		06/12/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
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()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 (75)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications arecorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for acc (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record auticlients of the control of t	istration: n-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. clinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:				
	This Rule is not met	as evidenced by:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL0601060	B. WING		06/12/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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			TE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	3	V 118			
	Based on observations, record review and interviews, the facility failed to ensure the MAR was kept current affecting 1 of 3 client (client #1). The findings are:					
	Review on 6/11/25 of Client #1's record revealed: - Admission date 10/11/19; - Diagnoses Intellectual Disability Mental Retardation Developmental Disorder, Bipolar, Depressive Disorder, Schizoaffective Disorder, Mood Disorder, Obesity Physician's order dated 4/16/25 Omega-3 (fish oil) 1,000 milligram (mg), Take 1 tablet daily.					
	Observations on 6/10/25 of Client #1's medication revealed: - Omega-3 1,000 mg was available.					
	Review on 6/10/25 and 6/11/25 of Client #1's MAR from March 1, 2025-June 9, 2025 revealed: - Omega-3 1,000 mg not listed on the MAR from March 2025-May 2025. Interview on 6/9/25 with Client #1 revealed: - Self administered medications daily.					
	the clients in the facili	l: completing the MARs for				
V 139	27G .0404 (F-L) Oper Period	rations During Licensed	V 139			
	10A NCAC 27G .0404 DURING LICENSED (f) DHSR shall condu- without advance notice	PERIOD act inspections of facilities				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 139	Continued From page	e 4	V 139			
V 100	(g) Licenses for faciliany clients during the not be renewed. (h) DHSR shall cond 24-hour facilities an amonths, to occur no la July 1, 2007. (i) Written requests sa minimum of 30 days changes: (1) Construction renovation of an exist (2) Increase or program service type (3) Change in partnership (4) Change in la Change in partnership (2) Change in rochange in discontinue a service days in advance shall affected clients, and rollegally responsible per This notice shall addreship clients in the facility. (I) Licenses shall exponents in the facility. (I) Licenses shall exponents in the facility. (I) Annual Fee (2) Description facility since the last rosubmitted;	ties that have not served previous 12 months shall uct inspections of all overage of once every 12 ater than 15 months as of shall be submitted to DHSR is prior to any of the following on of a new facility or any ting facility; decrease in capacity by groogram service; or ocation of facility. If the following service is one of a days prior to any of services or ocation of facility. If the following service is ownership including any or or name of facility. If the following service is ownership including any or or ocation of all affected clients. If the following services to be services to service in the following service in the following services to service in the following service; or occasion of facility. The following service is the following service; or occasion of facility. The following service is the following service; or occasion of facility or occasion of facility. The following service is the following service; or occasion of facility or occasion of facility. The following service is the following service; or occasion of facility or occasion of facility. The following service is the following service is the following service; or occasion of facility. The following service is the following service is the following service is the following service; or occasion of facility. The following service is the following service; or occasion of facility. The following service is the following service; or occasion of facility. The following service is the following service; or occasion of facility. The following service is the following servic				
		tation inspection report, with				

Division of Health Service Regulation

STATE FORM 6899 4ALM11 If continuation sheet 5 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		R	
		MHL0601060	B. WING		06/12/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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V 139	Continued From page	e 5	V 139			
	that does not handle inspection report is no (5) The names owner, partners or sh	y/night or periodic service food for which a sanitation ot required; and of individuals who are areholders holding an ng interest of 5% or more of				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide the required written documentation of emergency relocation of clients to the Department of Health Service Regulations (DHSR). The findings are:					
	Review on 6/10/25 of DHSR's emergency relocation folder revealed: - No emergency relocation application was provided by the facility.					
	 Air conditioner hasn "There is no air com Professional (QP)] is Spent several nights facility; 	ith Client #1 revealed: 't work since last year; ing out, [Owner/Qualified trying to get it prepared;" s at the Owner/QP's other n staying the weekend at sility.				
	Air conditioner has r"We went to [OwnerSlept on the floor in facility;	ith Client #2 revealed: not worked since last week; /QP]'s other location;" the living room at the other n staying the weekend at the cility.				

Division of Health Service Regulation

STATE FORM 6899 4ALM11 If continuation sheet 6 of 9

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
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		MHL0601060	B. WING		06/12/2025		
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			OODY RIDGE RO				
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
V 139	Continued From page	e 6	V 139				
	- Did not know how lonot been working in the rote of the process o	with Staff #1 revealed: out this month;" e Owner/QP's other house and 6/10/25 with the essional revealed: and not worked for 2 weeks; and emergency relocation ant #1, client #2) over to my mergency relocation ening of 6/9/25; ment for DHSR Construction come to the unlicensed been staying at ent #2 slept in the living					
	could stay in the facili						
V 754	27G .0304(c) Comfor	t Zone	V 754				
	EQUIPMENT (c) Comfort Zone: Ea	4 FACILITY DESIGN AND ach 24-hour facility shall					

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DIVISION	n nealth Service Regu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE SI		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
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		MHL0601060	B. WC		06/1	2/2025	
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		10000 WO	ODY RIDGE RO	DAD			
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		CHARLOT	TE, NC 20273				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE	
iAO		,	IAG	DEFICIENCY)			
			1				
V 754	Continued From page	e 7	V 754				
	maintain a comfort ra	nge between 68 and 80					
	degrees Fahrenheit.	nge between oo and oo					
	•	ment shall not apply to					
		ement shall not apply to					
	therapeutic (habilitativ	, .					
	24-hour facilities for s						
		ensed prior to October 1,					
		uired to add or install cooling					
	equipment if not alrea	ady installed.					
	This Rule is not met						
		ns and interviews, the facility					
		ing equipment to maintain a					
	comfort range between	_					
	Fahrenheit. The findir	ngs are:					
		he estimate detail from					
	heating and air techni	ician dated 5/23/25					
	revealed:						
	- Full system replacer	ment \$ 9, 595.00.					
		5 at approximately 5:44pm					
	of the thermostat, rea	d 88 degrees Fahrenheit.					
		ith Client #1 revealed:					
		't work since last year;					
	- "There is no air com	ing out, [Owner/Qualified					
	Professional (QP)] is	trying to get it prepared."					
	Interview on 6/9/25 w	ith Client #2 revealed:					
	- Air conditioner has r	not worked since last week.					
	Interview on 6/11/25 v	with Client #3 revealed:					
	- Did not know how lo	ong the air conditioner had					
	not been working in th						
	3 ···	•					
	Interview on 6/11/25 v	with Staff #1 revealed:					
	- "I think the air went						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		URVEY ETED
MHL0601060		B. WING		R 06/1	2/2025	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 00/1	2/2023
		10000 WO	ODY RIDGE RO			
ONE STE	P FORWARD OUTREACH		TE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 754	Continued From page	8	V 754			
	Owner/Qualified Profe - 6/9/25: - Air conditioner ha - The local heating the home on 5/23/25 for a full system repla - Planned to purchasystem from a neighb - Had to have a HV for the furnace to con - 6/10/25: - The air condition 6/19/25; - Received two air that will be placed in to could stay in the facilities - 6/12/25: - Received a call from come evaluate the home	d not worked for 2 weeks; and air technician came to and provided an estimate cement; ase a used air conditioning or; AC technician get the parts nect the air conditioning unit er would be fixed by conditioner window units he windows, so the clients ty.				

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