Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	mhl060-852		R 08/23/2018

NAME OF PROVIDER OR SUPPLIER: NEW VISION HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 5004 GLENVIEW COURT, CHARLOTTE, NC 28215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on August 23, 2018. The complaints were unsubstantiated (Intake #NC00133936 and NC00140484). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000	DHSR - Mental Health SEP 07 2018 Lic. & Cert. Section	
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	V 108		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin B. Robinson TITLE: CEO (X6) DATE: 9/4/18

Division of Health Service Regulation

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff received training to meet the nmh/dd/sa needs of the clients affecting 1 of 4 audited staff (Staff #5). The findings are: Review on 8/22/18 of Staff #5's record revealed: -Hire date of 8/16/17; -Employed as Direct Care Staff; -No documentation of training in sexualized behaviors/sexually reactive behaviors. Interview on 8/23/18 with the Executive Director/Licensee revealed: -Will arrange for Staff #5 to receive the necessary training.	V 108	Sexualized Behaviors/Sexual Reactive Behaviors will be included during new hire orientation. Prior to the a new employee first day of work the Executive Director will all prerequiste training are completed and documented. Effective 9/1/2018	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND 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	V 112		

Division of Health Service Regulation

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	mhl060-852		R 08/23/2018

NAME OF PROVIDER OR SUPPLIER: NEW VISION HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 5004 GLENVIEW COURT CHARLOTTE, NC 28215

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V 112	Continued From page 2 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.	V 112		
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement treatment plan strategies to address the needs of the clients affecting 3 of 4 audited clients (Clients #1, #2, and #3). The findings are: Review on 8/22/18 of Client #1's record revealed: -Admission date of 4/18/18; -17 years old; -Diagnoses of Major Depressive Disorder, Intellectual Developmental Delays, Attention Deficit Hyperactivity Disorder; -History of sexualized behaviors with males on the school bus and at school; -No treatment plan strategies to address sexualized behaviors. Review on 8/22/18 of Client #2's record revealed: -Admission date of 3/6/18;		Goals have been added to client #1,2 and 3 PCP to address inappropriate sexual behaviors, respecting others personal space as well as appropriate socialization skills. Goals for pending admissions with identified sexual behaviors will be implemented on the PCP prior to admission approval. This process will be monitored by the Qualified Professional at time of admission and during CFT meetings. Implementation date 9/1/18	

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V 112	Continued From page 3 -17 years old; -Diagnoses of Personality Disorder Unspecified, Adjustment Disorder Unspecified, Post-Traumatic Stress Disorder; -Recently made a false accusation of a sexual assault against a peer at day treatment after having consensual sexual contact with the peer. The accusation resulted in a rape kit assessment at the local emergency department and involvement with local law enforcement; -No treatment plan strategies to address false accusations of sexual assault or sexualized behaviors. Review on 8/22/18 of Client #3's record revealed: -Admission date of 7/12/18; -15 years old; -Diagnoses of Attention Deficit Hyperactivity Disorder, Autistic Disorder, Conduct Disorder, and Unspecified Intellectual Developmental Delay; -History of sexualized behaviors and multiple unsubstantiated sexual abuse allegations; -No treatment plan strategies to address false accusations of sexual assault or sexualized behaviors. Interview on 8/23/18 with the Executive Director/Licensee revealed: -Had already been in contact with the Local Management Entity to discuss revising the treatment plan strategies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112	See Previous	
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 117		

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V 117	Continued From page 4 REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on interview, record review, and observation, the facility failed to ensure pharmacy labels on all prescription medications affecting 1 of 4 audited clients (Client #3). The findings are: Observation on 8/22/18 at approximately 8:50am	V 117		

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V 117	Continued From page 5 of Client #3's medications revealed: -No pharmacy label affixed to Client #3's Saphris. Review on 8/22/18 of Client #3's record revealed: -Admission date of 7/12/18; -15 years old; -Diagnoses of Attention Deficit Hyperactivity Disorder, Autistic Disorder, Conduct Disorder, and Unspecified Intellectual Developmental Delay; -Physician's order dated 7/12/18 for Saphris (antipsychotic) 10mg 1 tab twice daily. Interview on 8/23/18 with the Executive Director/Licensee revealed: -Will ensure pharmacy labels on all medications.	V 117	Executive Director will ensure that all prescription received by the pharmacy have lables attached to actual medication as well as the packaging.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
mhl060-852 Y1	A. Building B. Wing Y2	8/23/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISION HOME	5004 GLENVIEW COURT CHARLOTTE, NC 28215

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0110	Correction	ID Prefix V0293	Correction	ID Prefix V0296	Correction
Reg. # 27G .0204	Completed	Reg. # 27G .1701	Completed	Reg. # 27G .1704	Completed
LSC	08/23/2018	LSC	08/23/2018	LSC	08/23/2018
ID Prefix V0367	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 27G .0604	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/23/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Eileen Sanchez	DATE 8/23/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE Robin B. Roberson EEO	DATE 9-4-18

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/7/2018	☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 27, 2018

Ms. Robin Roberson
Dreams and Vision, LLC
5736 North Tryon Street, Suite 130
Charlotte, NC 28213

Re: Annual, Complaint, and Follow Up Survey completed August 23, 2018
New Vision Home, 5004 Glenview Court, Charlotte, NC 28215
MHL # 060-852
E-mail Address: dreamsandvisions2011@yahoo.com
Intake #NC00133936 and NC00140484

Dear Ms. Roberson:

Thank you for the cooperation and courtesy extended during the annual, complaint, and follow up survey completed August 23, 2018. The complaints were unsubstantiated.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiency.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is September 22, 2018.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 22, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier, Team Leader at 704-596-4072.

Sincerely,

Eileen Sanchez, MA
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
Trey Sutten, Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
Ms. Peggy Eagan, Director, Mecklenburg County DSS
Pam Pridgen, Administrative Assistant
File