

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/18/2019
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NAME OF PROVIDER OR SUPPLIER NEW YORK HOMES RESIDENTIAL CARE CEN'	STREET ADDRESS, CITY, STATE, ZIP CODE 644 OLIVETTE ROAD ASHEVILLE, NC 28804
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(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	<p>INITIAL COMMENTS</p> <p>A limited follow up survey for the Type A1 was completed on 7/18/19. This was a limited follow up survey, only 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112), 10A NCAC 27G.5601 Scope (V289), 10A NCAC 27G 5603 Operations (V291) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112), 10A NCAC 27G.5601 Scope (V289), 10A NCAC 27G 5603 Operations (V291). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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