Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING			R
		MHL011-405	B. WING			06/2020
NAME OF P	ROVIDER OR SUPPLIER	STREE	r address, city, sta	ΓΕ, ZIP CODE		
NEWYOR	NA LIOMEO DEGIDENTIAL	644 OI	IVETTE ROAD			
NEW YOR	RK HOMES RESIDENTIAL	. CARE CENTER #4 ASHE	VILLE, NC 28804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000			
	completed on 2/6/20. unsubstantiated (Intal NC00160091). A defi	d for the following service 27G .5600F Supervised of all Disability				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person authoriugs. (2) Medications shall clients only when authorient's physician. (3) Medications, incluadministered only by unlicensed persons transmistered persons transmistered to prepare (4) A Medication Admall drugs administered current. Medications arecorded immediately MAR is to include the (A) client's name; (B) name, strength, and (C) instructions for add (D) date and time the (E) name or initials of drug.	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of to each client must be kept administered shall be after administration. The following:				

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

(X6) DATE TITLE

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-405	B. WING		02	R 2/06/2020	
	ROVIDER OR SUPPLIER	644 OL	ADDRESS, CITY, STATE VETTE ROAD ILLE, NC 28804	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ACTILEV TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	(X5) COMPLETE DATE		
V 118	checks shall be reco	e 1 rded and kept with the MAR pointment or consultation	V 118				
	review the facility fail for 1 of 3 audited clie Observation on 1/22/ Client #3 included:	n, interview, and record ed to keep the MAR current nts (#3). The findings are: 20 of the medications for tablet at bedtime in a pill					
	revealed: -Admitted on 10/27/1 Spectrum Disorder, S Diabetes and Expres	the record for Client #3 7 with diagnoses of Autism Severe Intellectual Disability, sive Language Disorder. ed 12/5/19 for Trazadone 50 e.					
		•					
	Living (AFL) Provided -She verified Trazado January 2020 MARIt was listed and doo 2019 MAR.	with the Alternative Family revealed: one was not listed on the cumented on the December e in a pill pack from the					

Division of Health Service Regulation

STATE FORM 6899 ODP211 If continuation sheet 2 of 3

PRINTED: 02/25/2020 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
							R	
		MHL011-405		B. WING		02/	06/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
NEW YORK HOMES RESIDENTIAL CARE CENTER #4 644 OLIVETTE ROAD ASHEVILLE, NC 28804								
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	pharmacy and was action and action action action action and action action and action	dministered. Ild have been document with the Vice President: e medications were ompared to the individuals ks and balances in place onth.	for ual t to R. ey e ion. II	V 118				

Division of Health Service Regulation

STATE FORM 6899 ODP211 If continuation sheet 3 of 3