PRINTED: 02/25/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-405	A. BUILDING: ____ B. WING ____	R 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 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 2/6/20. The complaints were unsubstantiated (Intake #NC00159068 and NC00160091). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.	V 000	RECEIVED By Mental Health Licensure & Cert. Section at 1:33 pm, Mar 06, 2020	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or	V 118		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Crystal Hall BSW QP

TITLE: QP

(X6) DATE: 3/6/2020

PRINTED: 02/25/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-406	A. BUILDING: ______ B. WING ______	R 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to keep the MAR current for 1 of 3 audited clients (#3). The findings are: Observation on 1/22/20 of the medications for Client #3 included: -Trazadone 50 mg 1 tablet at bedtime in a pill pack with nighttime medications. Review on 2/5/20 of the record for Client #3 revealed: -Admitted on 10/27/17 with diagnoses of Autism Spectrum Disorder, Severe Intellectual Disability, Diabetes and Expressive Language Disorder. -Physician order dated 12/5/19 for Trazadone 50 mg 1 tablet at bedtime. Review on 1/22/20 and 2/5/20 of the December 2019 and January 2020 MAR for Client #3 revealed: -No documentation of Trazadone 50mg administration from 1/1/20-1/21/20. Interview on 1/22/20 with the Alternative Family Living (AFL) Provider revealed: -She verified Trazadone was not listed on the January 2020 MAR. -It was listed and documented on the December 2019 MAR. -The Trazadone came in a pill pack from the	V 118	-QP will check the MAR monthly rather than Quarterly for 3 consecutive months. -~~Other~~ House managers within NY Homes will review eachothers MAR's to ensure all meds are correct.	

Division of Health Service Regulation
STATE FORM

PRINTED: 02/25/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-405	A. BUILDING: ______ B. WING ______	R 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW YORK HOMES RESIDENTIAL CARE CENTER #4	844 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 2 pharmacy and was administered. -The Trazadone should have been documented. Interview on 1/22/20 with the Vice President for the licensee revealed: -Each month when the medications were received, they were compared to the individual MAR for accuracy. -The facility had checks and balances in place but were missed this month. Interview on 2/5/20 with the Qualified Professional revealed: -The January 2020 preprinted MAR was sent to the office with the completed December MAR. -This was an oversight by the facility, and they had used the old MAR which did not have the Trazadone listed since it was a new medication. -The medications for the facility came in a pill pack from the pharmacy which included the Trazadone and was administered at bedtime.	V 118		

11 Hooper's Creek • Fletcher, NC 28732
Office: (828) 654-0901 • Fax: (828) 687-0420

Fax Transmittal Form

To: DHHS

From: Reach for Independence

Company:

Fax:

Urgent
For review
Please Comment

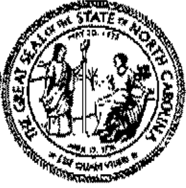
Date sent:
Time sent:
Number of pages including cover page: 6

MESSAGE:

Plan of Correction for New York homes #4 Residential Care Center.

Crystal Hall QP

Important warning: confidential notice *Unauthorized interception of this telephone communication could be a violation of Federal and State law. The documents which may accompany this telephonic transmission, along with this cover page, may contain confidential information which is legally privileged. The information is intended only for the use of the recipient listed above. You are hereby notified that any disclosure, copying distribution, or the taking of any action of the contents of this telecopied Information is strictly prohibited. If you received this telecopy in error, please destroy all pages of transmission.



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

February 26, 2020

Richard Charlton
New York Homes Residential Care Center, LLC
82 Ingle Road
Asheville, NC 28804

Re: Annual, Follow up and Complaint Survey completed 2/6/20
New York Homes Residential Care Center #4, 644 Olivette Road, Asheville, NC 28804
MHL # 011-405
E-mail Address: charltondynasty@aol.com; crystal.hale@reachforindependence.com
(Intake #NC00159068 & NC00160091)

Dear Mr. Charlton:

Thank you for the cooperation and courtesy extended during the annual, follow up and complaint survey completed 2/6/20. The complaints were unsubstantiated.

As a result of the follow up survey, it was determined that all 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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 4/6/20.

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.***

February 24, 2020
Richard Charlton
New York Residential Homes Residential Care Center, LLC

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 Sonia Eldridge, Team Leader at 828-665-9911.

Sincerely,

Sherry Waters
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant