

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhi060-852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/16/2021
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, follow up and complaint survey was completed on 6-16-21. The complaint was substantiated. (NC00177277). 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 JUL 9 2021 Lic. & Cert. Section	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 6-8-21 of disaster drills revealed: -Facility has three separate shifts; first,	V 114		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

CZ0711

If continuation sheet 1 of 5

Robin B Roberson CEO

7/16/2021

Division of Health Service Regulation

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V 114	Continued From page 1 second, and third. -Quarterly notes that disaster drills were done with the months listed, with no time or date. Interview on 6-16-21 with the Director revealed: -That is how they have always documented their disaster drills and it has never been a problem. -They are already working on a way to document the disaster drills the same way they do the fire drills. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	A new form has been completed to ensure all requirements are met. Form attached.	
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present	V 296		

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V 296	<p>Continued From page 2</p> <p>and one shall be awake for one through four children or adolescents;</p> <p>(2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and</p> <p>(3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents.</p> <p>(d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.</p> <p>(e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.</p> <p>This Rule is not met as evidenced by: Based on record review, interviews and observations the facility failed to ensure minimum number of direct care staff to meet client/staff ratio. The findings are:</p> <p>Observation on 6-1-21 at approximately 6:45 am to 7:45 am revealed: -One staff with five clients. -7:45 am second and third staff comes into facility.</p> <p>Review on 6-1-21 of the facility schedule</p>	V 296	<p>More staff have been hired to ensure that the minimum number of direct care staff are met by State regulations.</p>		

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V 296	Continued From page 3 revealed: -Staff #1 and Staff #2 were both scheduled to work from 11pm-7am May 31-June 1 2021. Interview on 6-1-21 with Client #1 revealed: -There is usually two to three staff at the facility. -Third shift usually has two people working. Interview on 6-1-21 with Client #2 revealed: -Staff working by themselves "barely happens." -The Director of the Qualified Professional will come in and work shifts when needed. Interview on 6-1-21 with Client #3 revealed: -It was common for one staff to work on third shift. -There is always at least two staff working on second and first shift. Interview on 6-1-21 with Client #7 revealed: -There is usually one staff on third shift, usually late at night. -"We are all asleep and not bothering anybody." -There have never been any incidents on third shift that she knows about. Interview on 6-1-21 with Staff #1 revealed: -She works third shift. -She has worked at the facility for several years. -She rarely works by herself. "it's been a minute." -Staff #2 was supposed to be working, but she didn't come in. -She did not call the Qualified Professional to let her know. "I know I should have." -There has never been any problems when	V 296			

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V 296	<p>Continued From page 4</p> <p>she has been there by herself.</p> <p>Interview on 6-1-21 with Staff #2 revealed:</p> <ul style="list-style-type: none"> -She normally works from 11pm to 7am. -I felt like it was OK for me to leave at 6:00am to get coffee. -When she left they were all asleep. <p>Interview on 6-11-21 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -Staff #2 had called her and told her she was running late because there was an accident on the road to work. -They have one staff that has to leave at 5:30am for dialysis and Staff #2 comes in. -She always makes sure there is the correct amount of staff scheduled. -She and the Director have also been working shifts to make sure they are in ratio. <p>Interview on 6-11-21 with the Director revealed:</p> <ul style="list-style-type: none"> -Staff #2 had left to get coffee. -She shouldn't have done it. -But that's rare, it's very rare." -She has been at the facility continually, working shifts to make sure there was coverage. -They have already talked to Staff #2 about leaving. 	V 296			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER mhl060-852	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/16/2021
NAME OF FACILITY NEW VISION HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 V0118	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 27G .0209 (C)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/16/2021	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

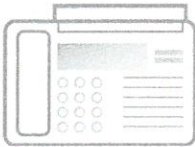
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR <i>Patricia Work</i>	DATE 6-16-21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/1/2019	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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F A X

Dreams and Visions, LLC.

5004 Glenview Ct
Charlotte, NC 28215
704-566-9734
Website



To: Patricia Work
Fax number: 919-715-8078

From: Robin Roberson
Fax number: 704-910-1761

Date: 7/6/2021

Regarding: Annual Complaint
Subject Survey

Phone number for follow-up:
Phone 704-281-7261

Comments: Original copies being mailed.
If any questions please contact
704-281-7261 Robin Roberson.

9 pages including cover page

DHSR - Mental Health

JUL 9 2021

Lic. & Cert. Section



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

June 18, 2021

DHSR - Mental Health

JUL 9 2021

Lic. & Cert. Section

Ms. Robin Roberson, Director
Dreams and Vision, LLC
5004 Glenview Court
Charlotte, NC 28215

Re: Annual, complaint, and follow up Survey completed 6-16-21
New Vision Home, 5004 Glenview Court, Charlotte NC 28215
MHL # 060-852
E-mail Address: dreamsandvision2011@yahoo.com
Intake # NC00177277

Dear Ms. Roberson:

Thank you for the cooperation and courtesy extended during the annual, complaint and follow up survey completed 6-16-21. The complaint was substantiated.

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 deficiencies.
- 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 7-16-21.
- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is 8-16-21.

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.).

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

June 18, 2021
New Vision Home
Ms. Robin Roberson

- 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 at 704-596-4072.

Sincerely,



Patricia Work
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: gmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant