

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mh1060-852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2022
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NAME OF PROVIDER OR SUPPLIER NEW VISION HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5004 GLENVIEW COURT CHARLOTTE, NC 28215
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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>An annual and complaint survey was completed n 3-25-22. The complaint was unsubstantiated (#NC00186948). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 1700 Residential Treatment Staff Secure For Children or Adolescents.</p> <p>This facility is licensed for six and currently has a census of five. The survey sample consisted of audits of three current clients.</p>	V 000		
V 295	<p>27G .1703 Residential Tx. Child/Adol - Req. for A P</p> <p>10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS</p> <p>(a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1).</p> <p>(b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following:</p> <p>(1) management of the day to day day-to-day operations of the facility;</p> <p>(2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and</p> <p>(3) participation in service planning meetings.</p>	V 295		

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

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V 295	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain at least one full time employee who met the requirements of an Associate Professional. The findings are:</p> <p>Review on 3-22-22 of facility's staff list revealed: -No staff identified as the Associate Professional.</p> <p>Interview on 3-22-22 with the Qualified Professional revealed: -She thought it might be a listed employee, but was not sure.</p> <p>Interview on 3-25-22 with the Director revealed: -Their Associate Professional had quit last year, approximately September 2021. -They have not been able to hire another Associate Professional yet. -All of the applicants had wanted more money than they could afford. -They will keep trying to hire an Associate Professional.</p>	V 295		