| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
|--|---|--|---------|-------------------------------|------------|--|--|
| | | | | | 06/28/2018 | | |
| | MHL0601117 | | B. WING | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALEXANDER YOUTH NETWORK - ELM STREET 6220-D THERMAL ROAD CHARLOTTE, NC 28211 CHARLOTE, NC 28211 | | | | | | | |
| | | | | | | | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | An annual survey was deficiency was cited. | s completed on 6/28/18. A | | | | | |
| | | d for the following service 27G .1900 Psychiatric t for Adolescents or | | | | | |
| V 118 | 27G .0209 (C) Medic | ation Requirements | V 118 | | | | |
| | only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclua administered only by unlicensed persons to pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record | n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be v after administration. The following: nd quantity of the drug; | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
|---|---|--|---|--|-------------------------------|-----------------|--|--|
| | | | B. WING | | 06/28/2018 | | | |
| | MHL0601117 | | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALEXANDER YOUTH NETWORK - ELM STREET 6220-D THERMAL ROAD CHARLOTTE, NC 28211 CHARLOTTE, NC 28211 | | | | | | | | |
| | | | | | | | | |
| PREFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | D THE APPROPRIATE | COMPLET DATE | | |
| V 118 | Continued From page | e 1 | V 118 | | | | | |
| | with a physician. | | | | | | | |
| | | | | | | | | |
| | This Rule is not met | as evidenced by: | | | | | | |
| | Based on records review, observations and interviews, the facility failed to ensure A Medication Administration Record (MAR) of all | | | | | | | |
| | drugs administered to current with medication | o each client was kept ons administered were | | | | | | |
| | recorded immediately affecting 3 of 3 client findings are: | y after administration s (#1, #2 and #3). The | | | | | | |
| | | f client #1's record revealed: | | | | | | |
| | Oppositional Defiant | 23/18 with diagnosis of Disorder, Attention Deficit er and Post Traumatic Stress | | | | | | |
| | Disorder (PTSD); -physicians' orders d | ated 5/23/18 for the following | | | | | | |
| | | dine 100mg one tablets zepine 600mg one tablet | | | | | | |
| | | ted 6/4/18 for Apripiprazole e daily; | | | | | | |
| | | g one tablet in the am; | | | | | | |
| | 20mg one tablet in th | ted 6/27/18 for Fluoxetine e am. | | | | | | |
| | Observations on 6/28 1:45pm of client #1's revealed: | | | | | | | |
| | | one tablets twice daily | | | | | | |
| | | ng one tablet twice daily | | | | | | |

STATE FORM

KR1K11

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|---|------------------------------------|-------------------------------|--|--|
| | | | B. WING | | | | | |
| | MHL0601117 | | | | 06 | 6/28/2018 | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL ROAD | | | | | | | | |
| ALEXAND | ER YOUTH NETWORK - | · ELM STREET | DTTE, NC 28211 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | | |
| V 118 | Continued From page | e 2 | V 118 | | | | | |
| | dispensed 6/20/18; -Fluoxetine 20mg one 6/27/18. Review on 6/28/18 of 5/23/18-6/28/18 revea dates left blank with r 6/28 am dose for Am twice daily, Oxcarbaz twice daily, Apripipraz daily, Lexothyroxine Fluoxetine 20mg one | g one tablet in the am e tablet in the am dispensed f client #1's MARs from aled the following dosing no explanation on the forms: antadine 100mg one tablets repine 600mg one tablet zole 10mg one tablet twice 125mg one tablet in the am, | | | | | | |
| | nurses. Finding #2: Review on 6/28/18 of -admission date of 10 PTSD; | ions daily from the the f client #2's record revealed: 0/17/17 with diagnoses of ted 5/6/18 for Amantadine | | | | | | |
| | -physician's order dat HCL 100mg one table | ted 10/17/17 for Sertraline et in the am; ted 6/20/18 for Apripiprazole | | | | | | |
| | dispensed 6/1/18; | medications on site one tablets twice daily ng one tablet in the am | | | | | | |

STATE FORM

KR1K11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|---|---|--|----------------------------------|-------------------------|--|--|
| | | | B. WING | | | | | |
| | MHL0601117 | | | | 06/28/2018 | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL ROAD 6220-D THERMAL ROAD | | | | | | | | |
| ALEXANDER YOUTH NETWORK - ELM STREET CHARLOTTE, NC 28211 | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | | |
| V 118 | Continued From page | e 3 | V 118 | | | | | |
| | 4/1/18-6/28/18 revea dates left blank with r 6/28 am dose for Am twice daily, Sertraline the am and Apripipra daily. Interview on 6/28/18 took her medications Finding #3: Review on 6/28/18 of -admission date of 4/ PTSD, Enuresis and -physician's order dat one tablet twice daily -physician's order dat 1mg one tablet twice -physician's order dat 50mg one tablet twice -physician's order dat 50mg one tablet twice -physician's order dat 50mg one tablet in th -physician's order dat Mycophenolate 200m Observations on 6/28 2:05pm of client #3's revealed: -Saphris 5mg one table 6/4/18; -Sertraline 50mg one 6/1/18; | f client #3's record revealed: 5/18 with diagnosis of Myasthenia Gravis; ted 6/20/18 for Saphris 5mg ; ted 5/9/18 for Guanfacine daily; ted 4/7/18 for Sertraline is am; ted 4/23/18 for ng 1.5 tablets twice daily. 8/18 at approximately medications on site olet twice daily dispensed is tablet twice daily dispensed | | | | | | |
| | -Mycophenolate 200r dispensed 5/8/18. | ng 1.5 tablets twice daily | | | | | | |
| | 4/5/18-6/28/18 revea | f client #3's MARs from led the following dosing no explanation on the forms: | | | | | | |

STATE FORM

| NUME MHL0601117 A. BUILDING: Other NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALEXANDER YOUTH NETWORK - ELM STREET 6220-D THERMAL ROAD CHARLOTTE, NC 28211 (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) V 118 Continued From page 4 V 118 | 6/28/2018 (X5) COMPLE DATE |
|--|-------------------------------------|
| AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LEXANDER YOUTH NETWORK - ELM STREET (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION IN | (X5) COMPLE |
| LEXANDER YOUTH NETWORK - ELM STREET 6220-D THERMAL ROAD CHARLOTTE, NC 28211 (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) | COMPLE |
| CHARLOTTE, NC 28211 (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) | COMPLE |
| CARLING Construction PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLE |
| V 118 Continued From page 4 V 118 | |
| | |
| 6/28 am dose for Saphris 5mg one tablet twice daily, Guantacine 1mg one tablet in the am and Mycophenolate 200mg 1.5 tablets twice daily. Interview on 6/28/18 with the Nurse revealed: -"I know we are supposed to sign when we give it but we got busy;" -"We are still right here;" -"It will be signed before we leave, you can be sure of that." Interview on 6/28/18 with Administrative Staff revealed: -was not aware of blank dosing dates on MARs; -issue will be addressed with the Nursing staff. | |

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