Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED			
			D MANAGE		R			
		MHL090-177	B. WING		06/03/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	FE, ZIP CODE				
ALEXAND	ALEXANDER YOUTH NETWORK-PORTER RIDGE 2843 RIDGE RD, CLASSROOMS E-102 & E-104 INDIAN TRAIL, NC 28079							
(VA) ID	QLIMMADV QT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	IN (VE)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	A follow up survey was Deficiencies were cite	as completed on 6-3-19. ed.						
	This facility is licensed for the following service category: 10A NCAC 27G 1400 Day Treatment							
	for Children and Adol Behavioral Disturban	escents with Emotional or ces.						
V 367	27G .0604 Incident R	eporting Requirements	V 367					
	10A NCAC 27G .0604 REPORTING REQUI	REMENTS FOR						
	CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable convision or while the							
	the provision of billable services or while the consumer is on the providers premises or level III							
		deaths involving the clients						
	90 days prior to the ir	rendered any service within nicident to the LME						
	responsible for the catchment area where							
	services are provided							
	becoming aware of the be submitted on a for	ne incident. The report shall m provided by the						
		t may be submitted via mail,						
	in person, facsimile o	r encrypted electronic						
		nall include the following						
	information: (1) reporting pr	ovider contact and						
	identification informat							
		fication information;						
	(3) type of incid							
	(4) description							
	. ,	e effort to determine the						
	cause of the incident;	and duals or authorities notified						
	(6) other individual or responding.	duals of authornes notined						
		providers shall explain any						
		e information. The provider						
	alth Service Pegulation	*	,		· · · · · · · · · · · · · · · · · · ·			

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

TITLE (X6) DATE

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Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		MHL090-177	B. WING		R 06/03/2019
	ROVIDER OR SUPPLIER	2843 R	ADDRESS, CITY, STATE	E, ZIP CODE DOMS E-102 & E-104	
ALEXANL	ER YOUTH NETWORK-P	ORTER RIDGE INDIAN	TRAIL, NC 28079		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 367	report recipients by the day whenever: (1) the provider information provided i erroneous, misleading (2) the provider required on the incide unavailable. (c) Category A and B upon request by the L obtained regarding the (1) hospital receinformation; (2) reports by o (3) the provider (d) Category A and B of all level III incident Mental Health, Develo Substance Abuse Ser becoming aware of the providers shall send a incidents involving a complete the commental of the commental than the providers of the client death within sever restraint, the provider immediately, as required to the catchment area where the report quarterly to the catchment area where the report shall be suby the Secretary via evinclude summary information of a level III (2) restrictive in	ed report to all required e end of the next business has reason to believe that in the report may be gor otherwise unreliable; or obtains information ent form that was previously providers shall submit, and the incident including: ords including confidential ther authorities; and is response to the incident, providers shall send a copy reports to the Division of preparental Disabilities and vices within 72 hours of e incident. Category A a copy of all level III client death to the Division of e incident. In cases of the incident. In cases of the incident in cases of the providers shall send a LME responsible for the e services are provided electronic means and shall remation as follows: errors that do not meet the	V 367		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL090-177		B. WING		06	R 5/ 03/2019
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
		DODTED DIDGE			ROOMS E-102 & E-104		
ALEXANL	ER YOUTH NETWORK-	PORTER RIDGE	INDIAN TR	AIL, NC 28079)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FILE OF THE STATE OF T	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 367	(4) seizures of the possession of a continuous (5) the total nutrincidents that occurre (6) a statement been no reportable in incidents have occurrence the any of the criterian (4) seizures of the total nutrincidents have occurrence to the criterian (4) seizures of the total nutrincidents o	f a client or his living ar client property or propertient; mber of level II and leved; and t indicating that there had a whenever no red during the quarter tria as set forth in Paragle and Subparagraphs	erty in rel III nave rhat graphs	V 367			
	facility failed to report Local Management E findings are: Review on 6-3-19 of 2019-June 3-2019 re	ews and interviews the tall Level II incidents to Entity within 72 hours. The incident reports for magivealed:	o the The				
	19, 5-29-19, 5-30-19. Review on 6-3-19 of Improvement System -Only the restrain were recorded in IRIS Management Entity. Interview on 6-3-19 v revealed: -The new Prograsuddenly and they we take her place.	nts on 5-2-19 and 5-10 S to notify the Local with the Administrator am Manager had left ere looking for someon st slipped through the c	se -19 e to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		COMP	X3) DATE SURVEY COMPLETED		
	MHI 090-177	B. WING			R 03/2019		
OVIDER OR SUPPLIER			TE, ZIP CODE	1 00/	03/2019		
AL EXANDER YOUTH NETWORK-PORTER RIDGE							
	INDIAN 1			CORRECTION	0.5		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
Continued From page	3	V 367					
This deficiency consti	tutes a re-cited deficiency	V 367					
	ROVIDER OR SUPPLIER ER YOUTH NETWORK-P SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page This deficiency consti	MHL090-177 ROVIDER OR SUPPLIER STREET AI ER YOUTH NETWORK-PORTER RIDGE 2843 RID	MHL090-177 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 2843 RIDGE RD, CLASSF INDIAN TRAIL, NC 28079 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 This deficiency constitutes a re-cited deficiency	MHL090-177 B. WING B. WING	MHL090-177 B. WING		

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