PRINTED: 10/04/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL060968 10/02/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL RD **ALEXANDER YOUTH NETWORK - CHARLOTTE DAY 1** CHARLOTTE, NC 28211 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 RECEIVED A complaint and follow up survey was completed By psammons at 5:57 am, Oct 20, 2019 on October 2, 2019. The complaint was unsubstantiated (Intake #NC 00156517). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances. V132 V 132 V 132 G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection What measures will be put in place to correct the deficient area of practice. G.S. §131E-256 HEALTH CARE PERSONNEL At the end of each day, Program Manager REGISTRY will meet face to face with a staff member from each (g) Health care facilities shall ensure that the group and inquire about any incidents that occurred Department is notified of all allegations against during the day. This will be documented on a daily log 10/16/19 health care personnel, including injuries of Program Manager will notify Executive unknown source, which appear to be related to Director of all incidents within 12 hour timeframe. 10/16/19 any act listed in subdivision (a)(1) of this section. Program Manager will receive coaching in (which includes: reporting when an incident occurs to the Executive a. Neglect or abuse of a resident in a healthcare Director to ensure proper escalation of procedures. 10/14/19 facility or a person to whom home care services If any incidents occur Program manager will as defined by G.S. 131E-136 or hospice services check to ensure documents are complete, and as defined by G.S. 131E-201 are being provided. determine what level the incident should be under. 10/14/19 b. Misappropriation of the property of a resident

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are being provided.

healthcare facility.

providing services).

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

Facilities must have evidence that all alleged

in a health care facility, as defined in subsection

(b) of this section including places where home

care services as defined by G.S. 131E-136 or

hospice services as defined by G.S. 131E-201

d. Diversion of drugs belonging to a health care

e. Fraud against a health care facility or against a patient or client for whom the employee is

c. Misappropriation of the property of a

facility or to a patient or client.

If the incident rises to a level 2 or 3 Program

Manager will ensure that critical incident information is

Program manager will ensure that

the proper authorities have been contacted and

10/14/19

10/14/19

complete.

notified of the incident.

Executive Director Day Tradment 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		JOHN LETED	
		MHL060968	B. WING		F 10/0	२ 02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	ER YOUTH NETWORK -	CHARLOTTE DAY 1 6220-D THE CHARLOTT	ERMAL RD TE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	to protect residents fro investigation is in prog investigations must be	and must make every effort om harm while the gress. The results of all e reported to the e working days of the initial	V 132	V132 Continued From page 1 Describe your plans to make sure the above On 10/4/19, Executive director divith Program Manager the prevention step and reviewed the policy and procedures for documenting incidents and reported allega abuse. Training and Program Improvem will provide day treatment staff with refresh on Incident Reporting policies and procedue. Program Manager will complete and other progressive documentation in sit which the correct documentation procedure not followed.	iscussed s above, r tions of ent team er training res. coaching uations in	10/21 /19
	failed to investigate al failed to protect clients investigation was in product and its staff. Review on 10/2/19 of -Admission date of 3/2-Diagnoses of Attention Disorder, Disruptive M Disorder, and Opposite-11 years old. Review on 10/2/19 of	nd record review, the facility all allegations of abuse and so from harm while the rogress affecting 2 of 3 Client #1's record revealed: 14/19; on Deficit Hyperactivity Mood Dysregulation tional Defiant Disorder; a Level I Incident Report		Who will monitor the situation to ensure it voccur again. The Executive Director will provious monitoring to ensure that the interventions are being met.	de	
	dated 8/1/19 revealed -Client #1 made an all regarding Staff #5 using the van. Interview on 10/2/19 was brought into the					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	:p.		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL060968	B. WING		R 10/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	DER YOUTH NETWORK -	CHARLOTTE DAY 1 6220-D THI CHARLOT	ERMAL RD TE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 132	van ride home; -Dates of the incidents Interview on 10/2/19 v revealed: -Had a meeting with 0 the end of September grandmother reported Staff #4 and Staff #5; -Did not complete an idid not suspend either -Will ensure to complet on any allegations of a Interview on 10/2/19 v revealed: -Will work closely with discuss a possible re-	nold by Staff #5 while on the s are unknown. with the Supervisor Client #1's grandmother at 2019 during which the staff the allegations involving internal investigation and r staff; ete an internal investigation	V 132			
V 318	The reporting by healt Department of all alleg personnel as defined including injuries of ur done within 24 hours of becoming aware of the health care facility	NVESTIGATING AND CARE PERSONNEL	V 318	V318 What measures will be put in place to correct deficient area of practice. • At the end of each day, Program will meet face to face with a staff member from group and inquire about any incidents that of during the day. This will be documented on exportance of all incidents within 12 hour timefrom Program Manager will receive coareporting when an incident occurs to the Exportance of the program of process of the program of the	Manager from each accurred a daily log 10/16/19 cutive rame. 10/16/19 aching in ecutive	

Division of Health Service Regulation

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		-	,	
		MHL060968	B. WING		10/0	2/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
ALEXAND	ER YOUTH NETWORK -	CHARLOTTE DAY 1	HERMAL RD				
			TTE, NC 28211				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETE DATE	
V 318	Continued From page	3	V 318	V318 continued from page 3			
V 310	This Rule is not met a Based on interview ar failed to notify the Dep becoming aware of ar staff affecting 2 of 3 a Review on 10/2/19 of -Admission date of 3/-Diagnoses of Attention Disorder, Disruptive Moisorder, and Oppositing -11 years old. Review on 10/2/19 of dated 8/1/19 revealed -Client #1 made an all regarding Staff #5 using the van. Interview on 10/2/19 well-was brought into the grabbed his shirt and wall; -Was put in a choke he van ride home; -Dates of the incidents. Interview on 10/2/19 werevealed: -Had a meeting with Country the end of September, grandmother reported Staff #4 and Staff #5; -Did not complete incidents of the allegations of at-Will ensure proper no	as evidenced by: and record review, the facility coartment within 24 hours of a allegation of abuse against udited staff. Client #1's record revealed: 14/19; an Deficit Hyperactivity flood Dysregulation cional Defiant Disorder; a Level I Incident Report : legation against Staff #5 and a choke hold while on with Client #1 revealed: library by Staff #4 who pushed him against the old by Staff #5 while on the are unknown. with the Supervisor client #1's grandmother at the allegations involving dent reporting or notification buse; diffication and	V 310	If any incidents occur Program my will check to ensure documents are completed termine what level the incident should be If the incident rises to a level 2 or Program Manager will ensure that critical in information is complete. Program manager will ensure that proper authorities have been contacted and of the incident. Describe your plans to make sure the above On 10/4/19, Executive director dis with Program Manager the prevention steps and reviewed the policy and procedures for documenting incidents and reported allegation abuse. Training and Program Improveme will provide day treatment staff with refreshed on Incident Reporting policies and procedure. Program Manager will complete conducted and other progressive documentation in situ which the correct documentation procedure followed. Who will monitor the situation to ensure it woccur again. The Executive Director will provide monitoring to ensure that the interventions a being met.	ete, and e under. or 3 or ident to the d notified e happens. scussed e above, dons of ent team er training es. coaching nations in s are not ellinot e	10/14/19 10/14/19 10/14/19 10/14/19 10/16/19	
	documentation in the f	future.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ALEXANI	DER YOUTH NETWORK -	CHARLOTTE DAY 1 6220-D THI CHARLOT	ERMAL RD TE, NC 28211			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
V 318	Continued From page	3 4	V 318			
	revealed: -Will work closely with discuss a possible re-	with the Executive Director the Supervisor and will earrangement of supervisory Executive Director's time at				
V 366	10A NCAC 27G .0603 RESPONSE REQUIR CATEGORY A AND B (a) Category A and B implement written poli- response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing a measures according t timeframes not to exc (4) developing a to prevent similar incid specified timeframes i (5) assigning pe for implementation of preventive measures; (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the in Paragraph (a) of this is shall address incident	REMENTS FOR PROVIDERS providers shall develop and icies governing their or III incidents. The policies der to respond by: the health and safety needs in the incident; the cause of the incident; the cause of the incident; and implementing corrective or provider specified eed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and confidentiality requirements rticle 2A, 10A NCAC 26B, and 45 CFR Parts 160 and documentation regarding through (a)(6) of this Rule, requirements set forth in Rule, ICF/MR providers is as required by the federal	V 366	V366 What measures will be put in place to corre deficient area of practice. • At the end of each day, Program will meet face to face with a staff member fr group and inquire about any incidents that during the day. This will be documented on • Program Manager will notify Exect Director of all incidents within 12 hour timef • Program Manager will receive correporting when an incident occurs to the Ext Director to ensure proper escalation of proceive to ensure documents are completed termine what level the incident should be • If the incident rises to a level 2 or Program Manager will ensure that critical in information is complete. • Program manager will ensure that proper authorities have been contacted and of the incident. Describe your plans to make sure the above on 10/4/19, Executive director dis with Program Manager the prevention steps and reviewed the policy and procedures for documenting incidents and reported allegat abuse. • Training and Program Improvement will provide day treatment staff with refresher.	Manager from each occurred a daily log cutive rame. aching in ecutive redures. anager te, and under. 3 cident the notified e happens. scussed a above, ions of ent team er training	10/16/19 10/14/19 10/14/19 10/14/19
	RESPONSE REQUIR CATEGORY A AND B (a) Category A and B implement written poli response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing a measures according to timeframes not to exc (4) developing a to prevent similar incides specified timeframes (5) assigning performing to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a) (1) (b) In addition to the in Paragraph (a) of this I shall address incident regulations in 42 CFR	REMENTS FOR B PROVIDERS Deproviders shall develop and licies governing their or III incidents. The policies der to respond by: the health and safety needs in the incident; the cause of the incident; and implementing corrective or provider specified eed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and confidentiality requirements ricicle 2A, 10A NCAC 26B, and 45 CFR Parts 160 and documentation regarding through (a)(6) of this Rule, requirements set forth in Rule, ICF/MR providers is as required by the federal		At the end of each day, Program will meet face to face with a staff member fr group and inquire about any incidents that during the day. This will be documented on Program Manager will notify Exect Director of all incidents within 12 hour timef Program Manager will receive correporting when an incident occurs to the Ext Director to ensure proper escalation of process of the ensure documents are complested determine what level the incident should be If the incident rises to a level 2 or Program Manager will ensure that critical in information is complete. Program manager will ensure that proper authorities have been contacted and of the incident. Describe your plans to make sure the above On 10/4/19, Executive director diswith Program Manager the prevention steps and reviewed the policy and procedures for documenting incidents and reported allegat abuse. Training and Program Improvements.	com each coccurred a daily log cutive rame. aching in ecutive redures. anager te, and under. 3 cident the notified e happens. scussed a above, dons of ent team er training	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL060968	B. WING		F 10/0	₹ 02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		6220-D THE				
ALEXAND	ER YOUTH NETWORK -	CHARLOTTE DAY 1 CHARLOTT	TE, NC 28211			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
V 366	Continued From page	5	V 366	V366 Continued From page 5	ooobina	
	Paragraph (a) of this I	Rule, Category A and B		 Program Manager will complete and other progressive documentation in sit 	-	
		CF/MR providers, shall	1	which the correct documentation procedure		
		nt written policies governing		followed.	s ale not	10/16/19
	•	vel III incident that occurs		Tollowed.		10/10/13
	•	elivering a billable service		Who will monitor the situation to ensure it w	vill not	
		n the provider's premises.		occur again.		
	by:	uire the provider to respond		The Executive Director will provide	de	
		securing the client record		monitoring to ensure that the interventions		
	by:			being met.		
		e client record;				
	(B) making a ph	notocopy;				
	(C) certifying the	e copy's completeness; and				
		the copy to an internal	ŀ			
	review team;					
	- · ·	meeting of an internal				
		hours of the incident. The				
		hall consist of individuals in the incident and who				
		for the client's direct care or				
		al oversight of the client's				
	•	the incident. The internal				
	review team shall com	plete all of the activities as				
	follows:					
	, ,	opy of the client record to				
		nd causes of the incident				
		dations for minimizing the				
	occurrence of future in	•				
	- ·	information needed;				
	(C) issue writter within five working day	n preliminary findings of fact				
		fact shall be sent to the				
		ent area the provider is				
		E where the client resides,				
	if different; and	•				
		written report signed by the				
	owner within three mo	nths of the incident. The				
	•	nt to the LME in whose				
	catchment area the pr	ovider is located and to the				
	Wh Coming Domilation					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL060968	B. WNG		R 10/02/2019	
	ROVIDER OR SUPPLIER PER YOUTH NETWORK -	CHARLOTTE DAY 1	RESS, CITY, STA ERMAL RD TE, NC 28211	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 366	final written report shall identified by the interrinclude all public docuincident, and shall marminimizing the occurring all documents needed available within three LME may give the prothree months to submit (3) immediately (A) the LME resarea where the service Rule .0604; (B) the LME which different; (C) the provider for maintaining and up treatment plan, if differentiation of the Department (E) the client's I applicable; and	resides, if different. The all address the issues hal review team, shall uments pertinent to the ake recommendations for ence of future incidents. If a for the report are not months of the incident, the evider an extension of up to notifying the following: ponsible for the catchment es are provided pursuant to here the client resides, if agency with responsibility odating the client's rent from the reporting	V 366			
	failed to implement the their response to incident Review on 10/2/19 of	nd record review, the facility eir written policy governing dents Client #1's record revealed:				
	-Admission date of 3/ -Diagnoses of Attention Disorder, Disruptive M	on Deficit Hyperactivity				

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STATE FORM 6899 NUNC11 If continuation sheet 7 of 12

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71101011	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		OOMI LETED	
		MHL060968	B. WING		R 10/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	ER YOUTH NETWORK -	CHARLOTTE DAY 1				
	,,,,,	CHARLOTT	E, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page	: 7	V 366			
	Disorder, and Opposite-11 years old.	tional Defiant Disorder;				
	-Was brought into the attempted to elope an shirt and pushed him -Dates of the incident Interview on 10/2/19 v revealed:	is unknown.				
	failure to complete an #1 attempted to elope #1 to the library to cal	incident report when Client and Staff #4 brought Client m down.				
	revealed: -Will work closely with discuss a possible re-	vith the Executive Director the Supervisor and will arrangement of supervisory Executive Director's time at				
V 367	27G .0604 Incident Re 10A NCAC 27G .0604 REPORTING REQUIF CATEGORY A AND B	INCIDENT REMENTS FOR PROVIDERS	V 367	V367 What measures will be put in place to correct deficient area of practice. At the end of each day, Program I will meet face to face with a staff member from the contract of the contract	Manager om each	
	(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the			group and inquire about any incidents that of during the day. This will be documented on Program Manager will notify Exec	a daily log.	10/16/19
	consumer is on the princidents and level II of to whom the provider	oviders premises or level III leaths involving the clients rendered any service within		Director of all incidents within 12 hour timefr Program Manager will receive coareporting when an incident occurs to the Exe	ame. iching in	10/16/19
	90 days prior to the in- responsible for the car services are provided becoming aware of the	chment area where		Director to ensure proper escalation of proce If any incidents occur Program ma will check to ensure documents are complet	edures. inager	10/14/19
	be submitted on a forr			determine what level the incident should be	under.	10/14/19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL060968	B. WING		F 10/0	R 02/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL RD CHARLOTTE, NC 28211							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 367	Secretary. The report in person, facsimile of means. The report shiftermation: (1) reporting providentification information: (2) client identification information: (3) type of incidentification of the incident; (4) description of the incident; (5) status of the cause of the incident; (6) other individent or responding. (b) Category A and B missing or incomplete shall submit an update report recipients by the day whenever: (1) the provider information provided if erroneous, misleading (2) the provider required on the incident unavailable. (c) Category A and B upon request by the Lobtained regarding the (1) hospital reconformation; (2) reports by of (3) the provider (4) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a conformation;	t may be submitted via mail, rencrypted electronic hall include the following ovider contact and ion; fication information; tent; of incident; effort to determine the and duals or authorities notified providers shall explain any information. The provider 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 int form that was previously providers shall submit, ME, other information e incident, including: ords including confidential ther authorities; and its response to the incident. providers shall send a copy reports to the Division of opmental Disabilities and vices within 72 hours of e incident. Category A	V 367	V367 Continued From page 8 If the incident rises to a level 2 or Program Manager will ensure that critical in information is complete. Program manager will ensure that proper authorities have been contacted and of the incident. Describe your plans to make sure the above. On 10/4/19, Executive director diswith Program Manager the prevention steps and reviewed the policy and procedures for documenting incidents and reported allegat abuse. Training and Program Improvement will provide day treatment staff with refreshed on Incident Reporting policies and procedure. Program Manager will complete of and other progressive documentation in situ which the correct documentation procedure followed. Who will monitor the situation to ensure it we occur again. The Executive Director will provide monitoring to ensure that the interventions a being met.	t the domination of the content team er training res. coaching uations in a are not team er training res. coaching uations in the coaching uations in	10/14/19 10/14/19 10/21/19	

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		MHL060968	B. WING		10/0	R 02/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	DER YOUTH NETWORK -	CHARLOTTE DAY 1	ERMAL RD			
	<u> </u>	CHARLOT	TE, NC 28211	eponential and the second of t		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	_	e incident. In cases of	V 367			
		en days of use of seclusion				
		ler shall report the death				
	.0300 and 10A NCAC	red by 10A NCAC 26C				
		providers shall send a				
		LME responsible for the				
		e services are provided. Ibmitted on a form provided				
		electronic means and shall				
	include summary info					
	` '	errors that do not meet the				
	definition of a level II (2) restrictive in	terventions that do not meet				
	, ,	I II or level III incident;				
	• *	a client or his living area;				
	(4) seizures of of the possession of a cl	client property or property in				
	·	nber of level II and level III				
	incidents that occurred					
		indicating that there have				
	been no reportable inc	cidents whenever no ed during the quarter that				
		a as set forth in Paragraphs				
	•	e and Subparagraphs (1)				
	through (4) of this Par	agraph.				
	This Rule is not met a	•				
		nd record review, the facility el III incidents to the LME				
***************************************	responsible for the car					
	services are provided	within 72 hours of				
	becoming aware of the	e incident.				
	Review on 10/2/19 of	Client #1's record revealed:				
	-Admission date of 3/1	14/19;				
	-Diagnoses of Attentio	n Deficit Hyperactivity				

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		В	
	-	MHL060968	B. WNG		R 10/02/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
ALEXAND	DER YOUTH NETWORK -	CHARLOTTE DAY 1	THERMAL RD OTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 367	Continued From page	10	V 367			
	Disorder, Disruptive N Disorder, and Opposit -11 years old.	flood Dysregulation tional Defiant Disorder;				
	dated 8/1/19 revealed -Client #1 made an al	a Level I Incident Report : legation against Staff #5 ng a choke hold while on				
	Response Improveme	eports completed on the				
	-Was brought into the grabbed his shirt and wall; -Was put in a choke h van ride home;	vith Client #1 revealed: library by Staff #4 who pushed him against the old by Staff #5 while on the				
	-Dates of the incidents	s are unknown.				
	the end of September grandmother reported Staff #4 and Staff #5; -No Level III incident r	Client #1's grandmother at 2019 during which the the allegations involving eports were completed				
	regarding the allegation -Will ensure to complete	ons of abuse. ete Level III incident reports	:			
	on all allegations of ab					
	revealed:	vith the Executive Director				
	discuss a possible re-	the Supervisor and will arrangement of supervisory Executive Director's time at				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ MHL060968 B. WING_ 10/02/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL RD ALEXANDER YOUTH NETWORK - CHARLOTTE DAY 1 CHARLOTTE, NC 28211 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 11 V 367 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

Division of Health Service Regulation

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