| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | | E SURVEY PLETED |
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| | | MHL0601117 | B. WING | | 05 | 5/25/2021 |
| AME OF PF | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | ZIP CODE | | |
| LEXAND | ER YOUTH NETWORK | - ELM UNIT | THERMAL ROAD DTTE, NC 28211 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 000 | INITIAL COMMENT | S | V 000 | | | |
| | completed on 5/25/2 unsubstantiated(Inta were cited. | at and follow-up survey was 1. The complaint was ake #175895). Deficiencies ed for the following service | | | | |
| | category:10A NCAC Residential Treatme | 27G .1900 Psychiatric nt Facility | | | | |
| V 113 | 27G .0206 Client Re | ecords | V 113 | | | |
| | (a) A client record sh individual admitted to contain, but need not (1) an identification find (A) name (last, first, (B) client record num (C) date of birth; | face sheet which includes: middle, maiden); nber; | | | | |
| | (D) race, gender and (E) admission date; (F) discharge date; (2) documentation o developmental disated diagnosis coded according | f mental illness, bilities or substance abuse | | | | |
| | ., . | ation or service plan; nation for each client which | | | | |
| | number of the perso sudden illness or act and telephone numb | ne, address and telephone n to be contacted in case of cident and the name, address per of the client's preferred | | | | |
| | responsible person g | ent from the client or legally granting permission to seek n a hospital or physician; f services provided: | | | | |
| | | f progress toward outcomes; | | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | | E SURVEY IPLETED | |
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| NAME OF PI | ROVIDER OR SUPPLIER | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| | | 6220-D ⁻ | THERMAL ROAD | , | | | |
| ALEXAND | ER YOUTH NETWORK | - ELM UNIT CHARLO | OTTE, NC 28211 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE D THE APPROPRIATE | (X5) COMPLET DATE | |
| V 113 | Continued From pag | e 1 | V 113 | | | | |
| | of Diseases (ICD-9-C (B) medication order (C) orders and copie (D) documentation or administration errors (b) Each facility shall relative to AIDS or re only in accordance w | to International Classification CM); s; s of lab tests; and | | | | | |
| | facility failed to ensur provided and docum outcomes was in the clients(#1, #2 and #3 Finding #1: Review on 5/17/21 a record revealed: -admission date of 7, -diagnoses of Post T Disorder(PTSD), Atte Disorder(ADHD), Au | view and interviews, the re documentation of services entation of progress toward client record affecting 3 of 3 3). The findings are: nd 5/18/21 of client #1's /16/20; | | | | | |
| | Mood Disorder; -admission assessm documented client # outbursts, aggression defiance, property defi | | | | | | |

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If continuation sheet 2 of 8

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | | E SURVEY PLETED |
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| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| | ER YOUTH NETWORK | - ELM LINIT 6220-D 1 | THERMAL ROAD | | | |
| ALEXAND | | CHARLO | OTTE, NC 28211 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE | (X5) COMPLET DATE |
| V 113 | Continued From pag | e 2 | V 113 | | | |
| | -Treatment plan date to learn behavior ma three coping skills, ir interaction, decrease outbursts, maintain h routine and participa Interview on 5/17/21 -saw his therapist too -see her almost ever Further review on 5/ #1's therapy progress revealed the followin -3/5 virtual check in s COVID-19 and quara -4/17 observed cliem activities; -4/29 meeting with cl supervisor and case consultation; -5/5 individual sessio -therapy notes with g documentation for th progress note: Sumr Recommendations to 4/8, 4/25, 4/30, 5/14. -documented in sect labeled "Change in F documented in Sect labeled "No Iss 4/30 and 5/14. Finding #2: Review on 5/17/21 o -admission date of 3. -diagnoses of PTSD, Explosive Disorder; | ed 5/21/21 documented goals inagement skills, identify increase positive peer a aggressive behaviors/anger healthy status, follow bedtime te in therapeutic leave. with client #1 revealed: day; y week. 17/21 and 5/18/21 of client s notes from 3/1/21-5/17/21 g documented: session with client #1 due to antine; t #1 in milieu/cottage linical supervisor, first shift manager for clinical case on with client #1; goals listed but no ie following sections of mary of Activity and Needs or to be Addressed for dates of to of therapy progress notes Risk to Self or Others" was ues" for dates of 4/8, 4/25, if client #2's record revealed: /16/21; , ADHD and Intermittent | | | | |
| | | 2 demonstrated aggression, e, property destruction, | | | | |

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| STATEMENT | of Health Service Regu T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC A. BUILDING: | | | E SURVEY PLETED |
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| | | MHL0601117 | B. WING | | 05 | /25/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | I | DDRESS, CITY, STATE, | , ZIP CODE | | |
| ALEXAND | DER YOUTH NETWORK | - FLM UNIT | THERMAL ROAD DTTE, NC 28211 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY 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) COMPLETE DATE |
| V 113 | Continued From pag | e 3 | V 113 | | | |
| | was a victim of negle domestic violence(D' -treatment plan dated to develop and utilize develop and utilize a management skills, r establish and follow a interaction with peers therapeutic leave. Interview on 5/17/21 -saw her therapist las -don't know how ofte Further review on 5/17 progress notes from following documente -4/17 observed client activities; -therapy notes with g documentation for th progress note: Sum Recommendations to 3/16, 4/8, 4/25, 4/30, -documented in secti labeled "Change in F | d 5/21/21 documented goals e healthy coping skills, ppropriate anger naintain healthy status, am/pm routine, have positive s and participate in with client #2 revealed: st week; n she sees her therapist. 17/21 of client #2's therapy 3/16/21-5/17/21 revealed the d: t #1 in milieu/cottage goals listed but no e following sections of nary of Activity and Needs or o be Addressed for dates of | | | | |
| | -admission date of 1/ -diagnoses of Adjustr Disturbances of Emo | ment Disorder with Mixed tions/Conduct and reaction | | | | |
| | elopements,threats to | - | | | | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | | E SURVEY PLETED |
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| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STATE, | ZIP CODE | | |
| ALEXAND | ER YOUTH NETWORK | - ELM UNIT | THERMAL ROAD DTTE, NC 28211 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY 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 113 | Continued From pag | e 4 | V 113 | | | |
| | DV, victim of neglect issues and had psychospitalizations; -Treatment plan date to stay in assigned a room clean, maintain as prescribed, command age appropriately, learn a age appropriately, learn a age appropriate inter follow night-time rout and participate in the Interview on 5/17/21 -saw his therapist a c -didn't see her last w Further review on 5/ progress notes from following documente -3/5 virtual check in s COVID-19 and quara -4/17 observed client activities; -therapy notes with g documentation for th progress note: Summ Recommendations to 4/8, 4/25, 4/30, 5/13; -documented in secti labeled "Change in F documented "No Issu 4/30 and 5/13. Interview on 5/24/21 -Been at the facilty a -was here from 2006 year ago. | i, food insecurities, anger hiatric inpatient ad 4/13/21 documented goals rea, eat food provided, keep in hygiene, take medications bunicate feelings and develop coping skills and raction skills, establish and time, follow bathroom routine erapeutic leave. with client #3 revealed: couple of weeks ago; reek. 17/21 of client #3's therapy 3/1/21-5/17/21 revealed the d: session with client #3 due to antine; t #1 in milieu/cottage goals listed but no e following sections of mary of Activity and Needs or to be Addressed for dates of a be Addressed for dates of the action of therapy progress notes Risk to Self or Others" was use" for dates of 4/8, 4/25, with the therapist revealed: total of 11 years; 6-2017, left then came back a | | | | |
| | | Elm Unit; eeing kids for individual ıny crisis, facilitate Child and | | | | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE, | ZIP CODE | | |
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| | | CHARLO | DTTE, NC 28211 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 113 | Continued From pag | e 5 | V 113 | | | |
| | Family Team meeting staffing and family se -client #1 does fantas -last saw him 5/14; -most of the time he -gets a chew toy to re -takes a lot of redired -a lot of restraints; -he was placed on se of 4/2021; -he had started bang nose bleed; -he was also biting h -last saw client #2 or -she has problems w -she is able to articul her triggers. -if she is triggered, sh tantrum; -during her last sessi being able to keep a -last saw client #3 or -has issues with bout -working on him aski -gets in others perso issues with peer inter better; -see clients for indivi- also go to cottage or cottage for some who -behind on notes in si in her notebook in he -not transposed in sy Interview on 5/25/21 | gs, authorizations, clinical essions as warranted; stic one on one; is one on one with staff here; educe him biting in himself; ction and prompts; elf-harm precautions at end ing his head and making his imself; o 5/14; rith emotional regulation; ate very well and can identify he will go into a full-blown ions, she got upset over not toy and had a tantrum; o 5/14; ndaries; ng for hugs; nal space/faces and causes ractions but doing much dual once a week; n weekends and observe in o do not do well in individual; system and have all sessions er handwriting; | | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | | E SURVEY PLETED |
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| | ROVIDER OR SUPPLIER | MHL0601117 | STREET ADDRESS, CITY, STATE, ZIP CODE | | 05/25/2021 | |
| | | 6220-D | THERMAL ROAD | | | |
| | ER YOUTH NETWORK - | ELM UNIT CHARL | OTTE, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLET DATE |
| V 738 | Continued From page | e 6 | V 738 | | | |
| V 738 | 27G .0303(d) Pest Co | ontrol | V 738 | | | |
| | 10A NCAC 27G .030 EXTERIOR REQUIR (d) Buildings shall be rodents. | | | | | |
| | | as evidenced by: ns and interviews, the facility n insects. The findings are: | | | | |
| | Interview on 5/17/21 -see bugs in her room -see spiders and ants -last night saw a big s | 5; | | | | |
| | Interview on 5/17/21 -saw bugs in his roon -saw a water cockroa -saw long time ago. | | | | | |
| | -granddaddy longlegs wall by closet in clien | 21 at 1:15pm revealed: s spider in upper corner of t #2's room; ck flying insects on floor by | | | | |
| | Interview on 5/19/21 -"I've been killing bug -"I hate this room." | with client #2 revealed: ıs;" | | | | |
| | Interview on 5/19/21 Executive Director re -the cottage is an old -not sure why bugs ir -maintenance staff do alth Service Regulation | vealed: building; | | | | |

STATE FORM

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OWMB11

If continuation sheet 7 of 8

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL0601117 | B. WING | | 05 | 25/2021 | |
| AME OF PF | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE, | ZIP CODE | | | |
| LEXAND | ER YOUTH NETWORK - | . ELM LINIT | THERMAL ROAD OTTE, NC 28211 | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION | | | | | | | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | THE APPROPRIATE | COMPLET DATE | |
| V 738 | Continued From page | e 7 | V 738 | | | | |
| | cottage; -will inform maintena | nce of issue. | | | | | |
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