

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL023-193</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>04/07/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALEXANDER YOUTH NETWORK-NORTH SHELBY DA'</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 CHARLES ROAD, ROOMS 102, 106 &amp; 107 SHELBY, NC 28152</b>
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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><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on April 7, 2025. The complaint was substantiated (intake #NC00228622). No deficiencies were cited.</p> <p>This facility is licensed for the following service 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.</p> <p>This facility has a current census of 12. The survey consisted of audits of 1 current client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_