| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |          | ` ′                 | E CONSTRUCTION  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|---|---|----------|---------------------|---|-----------------------------------|-------------------------------|--|--|
| AND I LAN OF CONNECTION                             |   |   | ···      | A. BUILDING:        |   | -                                 |                               |  |  |
|   | mhl060-972  |   | B. WING  |                     |   | C<br>07/30/2025                   |                               |  |  |
| NAME OF I   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  |   |          |                     |   |                                   |                               |  |  |
| ALEXAN  | ALEXANDER YOUTH NETWORK - DICKSON UI 6220 - B THERMAL ROAD CHARLOTTE, NC 28211  |   |          |                     |   |                                   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FI<br>SC IDENTIFYING INFORMAT  |          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | ΓΙΟΝ SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |  |
| V 000   | INITIAL COMMEN  | TS  |          | V 000               |   |                                   |                               |  |  |
|   | A complaint survey was completed on July 30, 2025. The complaints were substantiated (#NC00232227 and #NC00232235). A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children or Adolescents.   |   |          |                     |   |                                   |                               |  |  |
|   |   |   |          |                     |   |                                   |                               |  |  |
|   |   | sed for 6 and has a cu<br>urvey sample consisted<br>client.   |          |                     |   |                                   |                               |  |  |
| V 110   | <ul> <li>27G .0204 Training/Supervision Paraprofessionals</li> <li>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS <ul> <li>(a) There shall be no privileging requirements for paraprofessionals.</li> <li>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</li> </ul> </li> </ul> |   | V 110    |                     |   |                                   |                               |  |  |
|   |   |   |          |                     |   |                                   |                               |  |  |
|   | knowledge, skills a<br>population served.<br>(d) At such time as<br>employment systen<br>then qualified profe   | rals shall demonstrate and abilities required by a competency-based is established by rule essionals and associated demonstrate compete | emaking, |                     |   |                                   |                               |  |  |
|   |   | hall be demonstrated be including: ledge; ness; ;   |          |                     |   |                                   |                               |  |  |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | 5. I`´  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:                   |   | (X3) DATE SURVEY<br>COMPLETED     |                          |
|--|---|---|--|---|-----------------------------------|--------------------------|
| mhl060-972   |   |   | B. WING  | B. WING   |                                   |                          |
|  | PROVIDER OR SUPPLIER  | RK - DICKSON UI 622   | REET ADDRESS, CITY,<br>20 - B THERMAL R<br>IARLOTTE, NC 28 | OAD   | ·                                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION  |  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | ΓΙΟΝ SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 110  | (6) communication (7) clinical skills. (f) The governing be develop and impler for the initiation of the  |   | ures   |   |                                   |                          |
|  | interviews the facili (#2) demonstrated   | et as evidenced by:<br>view, photo review and<br>ty failed to ensure 1 of 2<br>knowledge, skills and ab<br>sulation served. The findi                                   | ilities  |   |                                   |                          |
|  | 6/24/25 at 7:11 pm -Client #1 was havi -Staff #2 went in Cl deescalate Client # -Client #1 continued -Former Staff (FS) and grabbed Client him out of the facilit | ng a behavior in his bedr<br>ient #1's bedroom tried to<br>1 but was unsuccessful.<br>d to scream very loudly.<br>#3 went in Client #1's roo<br>#1 by both arms and cal | om<br>rried  |   |                                   |                          |
|  | #1's Department of Guardian date 6/26 -pink and purple 2 i inner upper right ar armpit.   | of photo provided by Clie<br>Social Services (DSS) L<br>/25 revealed:<br>nch bruises on Client #1<br>m and the side of his right<br>tches on his inner upper            | egal<br>'s<br>nt   |   |                                   |                          |

Division of Health Service Regulation
STATE FORM

ROJK11 If continuation sheet 2 of 4

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY COMPLETED |                          |  |
|--|---|---|--|--|----------------------------|--------------------------|--|
| mhl060-972   |   |   | B. WING                                  |  |                            | C<br><b>07/30/2025</b>   |  |
|  | PROVIDER OR SUPPLIER  | BK DICKSON III 6220 - B   | DRESS, CITY, STHERMAL ROTTE, NC 282      |  |                            |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY) | .D BE                      | (X5)<br>COMPLETE<br>DATE |  |
| V 110  | Continued From pa   | ge 2  | V 110                                    |  |                            |                          |  |
|  | -On 6/24/25, we wahim to shower but he "I started screamin mad." -Staff #2 came in his he wanted to be lefter."[FS #3] came and really hard and carroffice." -Had bruises on bour grabbed him"I said, "stop! You'nelt safe at the factor of the safe at the safe at the factor of the safe at the safe at the factor of the safe at | g and cursing because I was s bedroom to talk to him but talone. grabbed me by my arms ied me to the manager's th of his arms where FS #3 re hurting me."" illity.  With FS #3 on 7/21/25 and successful.  With Staff #2 revealed: as asked to help deescalate as bedroom screaming and I not know why he was upset. deescalating Client #1. ent #1's bedroom and grabbed 'him out of the facility. rabbed Client #1  grab to management. |  |  |                            |                          |  |
|  | Legal Guardian on<br>-Conducted an inter-<br>-Staff #1, #2 and F3<br>-Staff #2 did not rep  | ed:<br>dent from Client #1's DSS<br>6/26/25.  |  |  |                            |                          |  |

Division of Health Service Regulation

STATE FORM 6899 ROJK11 If continuation sheet 3 of 4

| AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |                  | (X3) DATE SURVEY COMPLETED |  |  |
|--|--|--|--|--|--|------------------|----------------------------|--|--|
|  |  |  |  | D WINC                                   |  |                  | С                          |  |  |
|  |  | mhl060-972   |  | B. WING                                  |  | 07/3             | 30/2025                    |  |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE             |  |  |  |  |  |                  |                            |  |  |
| ALEXANDER YOUTH NETWORK - DICKSON UI 6220 - B THERMAL ROAD CHARLOTTE, NC 28211 |  |  |  |  |  |                  |                            |  |  |
| (X4) ID  |  |  |  |  |  |                  |                            |  |  |
| PREFIX<br>TAG  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | COMPLETE<br>DATE |                            |  |  |
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6899

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