

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060968	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/30/2025
NAME OF PROVIDER OR SUPPLIER ALEXANDER YOUTH NETWORK - CHARLOTTE		STREET ADDRESS, CITY, STATE, ZIP CODE 6220-D THERMAL RD CHARLOTTE, NC 28211		
(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	INITIAL COMMENTS A complaint survey was completed on April 30, 2025. The complaints were substantiated (intake #NC00228706 and #NC00228713). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and adolescents with Emotional or Behavioral Disturbances. This facility has a current census of 30 . The survey sample consisted of audits of 1 current client. This Statement of Deficiencies was amended on 9/9/25 as a result of the informal meeting on 7/22/25. Rule 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or exploitation was amended from a Type A1 to a Type B in Rule 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge;	V 109		

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

TITLE

(X6) DATE

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V 109	Continued From page 1 (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills, and abilities to meet the needs of clients. The findings are: Review on 4/16/25 of Client #1's record revealed: - 9 years old -Diagnoses of Oppositional Defiant Disorder and Posttraumatic Stress Disorder Review on 4/21/25 of the QP's personnel record revealed: -Date of hire 2/28/22	V 109			

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V 109	Continued From page 2 -Job Title QP. -Abuse training on 9/18/24. Review on 4/21/25 at 12:00pm of the Facility's Video Footage dated 3/14/25 revealed: -Client #1 was seen sitting in his chair. -The QP got up from her seat, walked over to Client #1, pulled him to the floor and then walked back to her seat. -Client #1 got up off the floor and sat in his chair. Review on 4/16/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -On 3/19/25 while reviewing video footage in reference to another incident, the Program Supervisor saw the QP walk over to Client #1 and pushed him out of his chair on 3/14/25. -Client #1 fell to the floor. -The QP walked back over to her seat and Client #1 got up and sat in his chair. Review on 4/21/25 of the facility's document titled "Internal Review Findings of Fact Summary- 3.31.24: Incident 3.19.25 revealed: -"Allegation: While reviewing video for another Internal Investigation, program manager (Program Supervisor) saw staff (QP) pull client (Client #1) off a desk and throw the to the floor. -The video shows the staff member (QP) approaching the youth (Client #1) after an exchange of words and then the youth is on the floor. The video is dark. -The youth (Client #1) is repeatedly saying dummy. The staff member (QP) can be heard saying 'Don't start with me today, I'm the wrong one.' After the physical exchanged the youth challenged the staff verbally to which she stated, 'I just did something about it.' -The cause of the incident is seen as staff member (QP) exacting revenge on the youth	V 109			

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V 109	Continued From page 3 (Client #1) for challenging her. Staff was reactionary. -Recommendations: It is recommended that the staff member (QP) be on a 60-day Performance Improvement Plan during which time she completed TCI (therapeutic crisis intervention) refresher training with a concentration on Handle with Care concepts that assist with being proactive and utilizing verbal de-escalation techniques as well as positive engagement strategies." Interview on 4/21/25 with the Program Supervisor revealed: -On 3/19/25 he was reviewing video footage in reference to another incident when he came upon footage of the QP pushing Client #1 out of his chair on 3/14/25. -Completed the NC IRIS report and reported the incident to Human Resources (HR) on 3/20/25. -HR did the internal investigation (3/27/25-3/31/25). -Did not question the QP. -Did not know the outcome of the internal investigation. -Client #1 did not sustain any injuries. Attempted interview on 4/25/25 with Client #1 revealed: -His legal guardian would not consent to an interview because Client #1 "does not speak good english and he has trouble following conversations." Interview on 4/28/25 with Staff #2 revealed: -Did not remember a lot of the details of the incident between the QP and Client #1 on 3/14/25. -Remembered Client #1 was disrupting the other clients and "talking back, calling staff names like	V 109		

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V 109	Continued From page 4 black B***h." - "Whatever you saw on the video is what happened. I think she (QP) just lost her cool for a minute. That kid (Client #1) would push and push and push." - Did not hear the QP and Client #1 arguing with each other. - Did not know if Client #1 sustained any injuries. Interview on 4/28/25 the QP revealed: - On 3/14/25, Client #1 kept using the saying "clock that tea" and in a jokingly way she said "I will." - "I walked over to his desk and tickled him and he wiggled out of his chair. I was playing with him, I wasn't trying to harm him." - "I'm not that kind of person to harm children." - "It was a playful interaction." - Denied telling Client #1 "Don't start with me today, I'm the wrong one." - Denied Client #1 was standing in his chair yelling "Dummy." - Did not pull Client #1 out of his chair on to the floor. Interview on 4/22/25 with the HR Director revealed: - The QP was suspended from the day program pending investigation on 3/27/25. - The QP worked with another program while under investigation. - The internal investigation took place from 3/27/25 to 3/31/25. - The QP was put on a 60 day performance plan. - The QP had to retake TCI training, "Handle with Care" on 3/31/25. Interview on 4/29/25 with the Vice President of Performance Improvement revealed: - Did not have a lot of details about the incident	V 109			

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V 109	Continued From page 5 between the QP and Client #1. -Verified the QP was allowed to work in another Program while under investigation for abusing Client #1. -The internal investigation was 3/27/25 through 3/31/25. -The QP was terminated on 4/30/25. Review on 4/30/25 of the Plan of Protection dated 4/30/25 signed by the Vice President of Performance Improvement revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? [QP] was terminated from employment with [Licensee] on 4/29/2025 and has not worked with any children since 4/4/2025. Describe your plans to make sure the above happens. Human Resources has removed [QP] access to all systems and locations effective 4/29/2025." Client #1 was 9 years old with diagnoses of Oppositional Defiant Disorder and Post Traumatic Stress Disorder. On 3/19/25, Client #1 was seen on a video from 3/14/25 sitting in his chair. The Qualified Professional got up from her seat, walked over to Client #1, grabbed him, pulled him to the floor, and then walked back to her seat. Client #1 got up off the floor and sat in his chair. This deficiency constitutes a Type B violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 109			
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection	V 132			

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V 132	Continued From page 6 G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident 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 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to protect clients during an investigation of abuse, neglect or exploitation. The findings are:	V 132			

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V 132	Continued From page 7 Review on 4/21/25 of the Qualified Professional's (QP) personnel record revealed: -Date of hire 2/28/22 -Job Title QP. Review on 4/21/25 at 12:00pm of the Facility's Video Footage dated 3/14/25 revealed: -Client #1 was seen sitting in his chair. -The QP got up from her seat, walked over to Client #1, pulled him to the floor and then walked back to her seat. -Client #1 got up off the floor and sat in his chair. Review on 4/16/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -On 3/19/25 while reviewing video footage in reference to another incident, the Program Supervisor saw the QP walk over to Client #1 and pushed him out of his chair on 3/14/25. -Client #1 fell to the floor. -The QP walked back over to her seat and Client #1 got up and sat in his chair. Review on 4/21/25 of the facility's document titled "Internal Review Findings of Fact Summary- 3.31.24: Incident 3.19.25" revealed: -"Allegation: While reviewing video for another Internal Investigation, program manager saw staff (QP) pull client (Client #1) off a desk and 'throw the to the floor.' " -"The video shows the staff member (QP) approaching the youth (Client #1) after an exchange of words and then the youth is on the floor. The video is dark." -"The youth (Client #1) is repeatedly saying 'dummy.' The staff member (QP) can be heard saying 'Don't start with me today, I'm the wrong one.' After the physical exchanged the youth challenged the staff verbally to which she stated, 'I just did something about it.' "	V 132			

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V 132	Continued From page 8 - "The cause of the incident is seen as staff member (QP) exacting revenge on the youth (Client #1) for challenging her. Staff was reactionary." - "Recommendations: It is recommended that the staff member (QP) be on a 60-day Performance Improvement Plan during which time she completed TCI (therapeutic crisis intervention) refresher training with a concentration on Handle with Care concepts that assist with being proactive and utilizing verbal de-escalation techniques as well as positive engagement strategies." Interview on 4/21/25 with the Program Supervisor revealed: - On 3/19/25 he was reviewing video footage in reference to another incident when he came upon footage of the QP pushing Client #1 out of his chair on 3/14/25. - Completed the NC IRIS report and reported the incident to Human Resources (HR) on 3/20/25. - HR did the internal investigation (3/27/25-3/31/25). - Did not question the QP. - Did not know the outcome of the internal investigation. - Client #1 did not sustain any injuries. Attempted interview on 4/25/25 with Client #1 revealed: - His legal guardian would not consent to an interview because Client #1 "does not speak good english and he has trouble following conversations." Interview on 4/28/25 with Staff #2 revealed: - Did not remember a lot of the details of the incident between the QP and Client #1 on 3/14/25.	V 132			

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V 132	Continued From page 9 -Remembered Client #1 was disrupting the other clients and "talking back, calling staff names like black B**ch." -"Whatever you saw on the video is what happened. I think she (QP) just lost her cool for a minute. That kid (Client #1) would push and push and push." -Did not hear the QP and Client #1 arguing with each other. Interview on 4/28/25 the QP revealed: -On 3/14/25 Client #1 kept using the saying "clock that tea" and in a jokingly way she said "I will." -"I walked over to his desk and tickled him and he wiggled out of his chair. I was playing with him, I wasn't trying to harm him." -"I'm not that kind of person to harm children." -"It was a playful interaction." -Denied telling Client #1 "Don't start with me today, I'm the wrong one." -Denied Client #1 was standing in his chair yelling "Dummy." -Did not pull Client #1 out of his chair on to the floor. -Could not recall which days she worked between 3/27/25 and 3/31/25. Interview on 4/22/25 with the HR Director revealed: -The QP was suspended from the day program pending investigation on 3/27/25. -The QP worked with another program while under investigation. -The internal investigation took place from 3/27/25 to 3/31/25. -Did not know the QP was not supposed to work with any clients while under investigation. -"I thought the suspension was just for the day program."	V 132		

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V 132	Continued From page 10 Interview on 4/29/25 with the Vice President of Performance Improvement revealed: -Did not have a lot of details about the incident between the QP and Client #1. -Verified the QP was allowed to work in another Program while under investigation for abusing Client #1. -The internal investigation was 3/27/25 through 3/31/25. -The QP was terminated on 4/29/25.	V 132		