Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1051-151	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED FAMILY NETWORK AT RIDGE ROAD	1259 RIDGE ROAD ANGIER, NC 27501

(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 An annual survey was completed on May 23, 2018. There was a deficiencies cited. This facility is licensed for the following service category: 10A NCAC 27G. 1300 Residential Treatment for Children or Adolescents	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl051-151	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED FAMILY NETWORK AT RIDGE ROAD	1259 RIDGE ROAD ANGIER, NC 27501

(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 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess and document the client's capability of having unsupervised time in the community in the treatment or habilitation plan affecting three of three audited clients (#1, #2 and #3). The findings are: Review on 5/23/18 of Client #1's record revealed: - Admission date 10/23/17. - Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Intermittent Explosive Disorder and Borderline Intellectual Functioning. - Treatment Plan dated 4/5/18. - There was no independent living skills goal that included unsupervised time and hours. - There was no assessment that demonstrated client was capable of unsupervised in the community. Review on 5/23/18 of Client #2's record revealed: - Admission date 5/26/17. - Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Oppositional Defiant Disorder, Anxiety Disorder and Major Depressive Disorder. - Treatment Plan dated 2/6/18. - There was no independent living skills goal that included unsupervised time and hours. - There was no assessment that demonstrated client was capable of unsupervised in the community. Review on 5/23/18 of Client #3's record revealed: - Admission date 7/20/15. - Diagnoses of Schizoaffective Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Seizure Disorder. - Treatment Plan dated 2/6/18.	V 112	V112-CFT meetings facilitated on 5/31/18 and an independent living skills goal was added to each client's person centered plan. -Assessment to evaluate Clients ability to be unsupervised in the community was completed on 5/31/18 -Provider will continue to monitor and document Client's progress during monthly CFT. - A goal to include unsupervised time and an assessment will be included in each future residents plan once CFT members deem appropriate -Will be monitored by QP Simmons monthly	5/31/18 5/31/18 Ongoing Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1051-151	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED FAMILY NETWORK AT RIDGE ROAD	1259 RIDGE ROAD ANGIER, NC 27501

(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 112	Continued From page 2 - There was no independent living skills goal that included unsupervised time and hours. - There was no assessment that demonstrated client was capable of unsupervised in the community. Interview on 5/23/18 with the Executive Director revealed: -The clients were being prepared to transition out of the facility. -The clients had not displayed any aggression. -The clients participated in community activities with staff. -The clients were involved in a boxing program, and client #3 volunteers at the Track Meets. -Clients participated in weekly group counseling and individual therapy. -The clients were allowed 1-3 hours of unsupervised time to go to the library or park. -Clients progress were reviewed monthly and documented. -He reported unsupervised time was assessed, discussed and determined during treatment team meetings. -He was not aware unsupervised time was not documented. -He would implement an assessment that demonstrated client's capability of unsupervised time.	V 112		

Addressee	Start Time	Time	Prints	Result	Note
9197333207	06-11 13:04	00:00:56	000/006	No Ans	FWD

Note TMR:Timer TX, POL:Polling, ORG:Original Size Setting, FME:Frame Erase TX, DPG:Page Separation TX, MIX:Mixed Original TX, CALL:Manual TX, CSRC:CSRC, FWD:Forward, PC:PC-FAX, BND:Double-Sided Binding Direction, SP:Special Original, FCODE:F-code, RTX:Re-TX, RLY:Relay, MBX:Confidential, BUL:Bulletin, SIP:SIP Fax, IPADR:IP Address Fax, I-FAX:Internet Fax

Result OK: Communication OK, S-OK: Stop Communication, PW-OFF: Power Switch OFF, TEL: Rx from TEL, NG: Other Error, Cont: Continue, No Ans: No Answer, Refuse: Receipt Refused, Busy: Busy, M-Full:Memory Full, LOVR:Receiving length Over, POVR:Receiving page Over, FIL:File Error, DC:Decode Error, MDN:MDN Response Error, DSN:DSN Response Error, PRINT:Compulsory Memory Document Print, DEL:Compulsory Memory Document Delete, SEND:Compulsory Memory Document Send.

UNITED FAMILY NETWORK

FACSIMILE TRANSMITTAL SHEET

TO: NC Department of Health and Human Services	FROM: Chris Simmons
COMPANY: Division of Health Service Regulation	DATE: 6/11/2018
FAX NUMBER: 919-715-8078	TOTAL NO. OF PAGES, INCLUDING COVER: 6
PHONE NUMBER: 919-855-3795	SENDER'S REFERENCE NUMBER: 910-578-6806
RE: Annual Survey	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

CONFIDENTIALITY NOTICE:

The documents accompanying this fax transmission contain confidential and privileged information protected by state and federal regulations. This information is intended only for the use of individuals or agency name above. The recipient is prohibited from making any further discloser of this information, except with the specific written consent of the person to whom it pertains. If you have received any of this communication in error, please notify us immediately by phone or fax.