STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		BERTH IO/ HON NOMBER.	A. BUILDING:			
MHL051-151		B. WING			R 02/16/2024	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NITED I	FAMILY NETWORK A	T RIDGE ROAD	OGE ROAD			
			, NC 27501			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	on February 16, 20	plaint survey was completed 24. The complaint was e #NC00212492. Deficiencies				
	category: 10A NCA	sed for the following service C 27G .1700 Residential cure for Children or				
	census of 3. The su	sed for 4 and currently has a urvey sample consisted of clients & 1 former client.				
	sister facility will be	entified in this report. The identified as sister facility A. A ed using the letter of the rical identifier.				
V 109	27G .0203 Privilegi	ng/Training Professionals	V 109			
	QUALIFIED PROF ASSOCIATE PROF (a) There shall be					
	professionals shall and abilities require (c) At such time as employment system	ssionals and associate demonstrate knowledge, skills ed by the population served. a competency-based n is established by rulemaking ssionals and associate				
	professionals shall					
	(1) technical known(2) cultural awaren(3) analytical skills(4) decision-makin	iess; ;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL051-151		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL051-151	B. WING			R 16/2024
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
INITED	FAMILY NETWORK A	T RIDGE ROAD	DGE ROAD			
	SUMMA DV STA		, NC 27501	PROVIDER'S PLAN OF		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 109	Continued From pa	ige 1	V 109			
	NCAC 27G .0104 (met the requirement employment system MH/DD/SAS. (f) The governing to develop and implem for the initiation of a plan upon hiring ea (g) The associate p supervised by a qua population served f	a skills; and ssionals as specified in 10A 18)(a) are deemed to have nts of the competency-based in in the State Plan for body for each facility shall ment policies and procedures an individualized supervision ch associate professional. professional shall be alified professional with the for the period of time as 104 of this Subchapter.				
	failed to ensure 1 o (QP)/(Licensee #1/ skills and abilities re served. The finding Review on 2/13/24	view and interview the facility f 2 Qualified Professionals QP) demonstrated knowledge equired by the population is are: of the Licensee #1/QP's	,			
	- the Licensee #	/03 2/9/24 client #1 reported: 1/QP told clients "you going to ad to hear the Licensee #1/QP				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL051-151	B. WING		R 02/16/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
JNITED	FAMILY NETWORK A	T RIDGE ROAD	DGE ROAD , NC 27501			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 109	Continued From pa	ge 2	V 109			
	 the Licensee # jail when you get ou he compared c clients that had beh 	lients with no behaviors to naviors different problems and should				
	Department of Soci - FC#4 informed FC #4, he would en - there were time during behaviors, h would go to jail - FC#4 informed the comments often	es the Licensee #1/QP told hin e would call the law and he her the Licensee #1/QP made n 1/QP had told her on visits "the	: n e			
	reported: - during group, h behaviors of stealin behaviors - he informed the	2/13/24 the Licensee #1/QP e discussed the clients' ig & inappropriate touching em if they continued with the ney could end up incarcerated				
	reported:	2/13/24 the Licensee #2/QP d be discussed in therapeutic				
V 293	10A NCAC 27G .17 (a) A residential tre children or adolesc	atment staff secure facility for	V 293			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		BENTH IOA TON NOMBER.	A. BUILDING:			
		B. WING		R 02/16/2024		
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
			GE ROAD			
NITED	FAMILY NETWORK A	ANGIER,	NC 27501			
(X4) ID			ID	PROVIDER'S PLAN OF CO		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		DATE
				DEFICIENCY)		
V 293	Continued From pa	ge 3	V 293			
	intensive, active the	erapeutic treatment and				
		a system of care approach. It				
		nary residence of an individual				
	who is not a client of					
		eans staff are required to be				
	awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of					
	this Section.					
	(c) The population served shall be children or					
	adolescents who have a primary diagnosis of					
	mental illness, emotional disturbance or					
	substance-related disorders; and may also have					
	co-occurring disorders including developmental disabilities. These children or adolescents shall					
	not meet criteria for inpatient psychiatric services.					
		adolescents served shall				
	require the following					
		rom home to a				
		esidential setting in order to				
	facilitate treatment;					
	(2) treatment (e) Services shall b	in a staff secure setting.				
		dividualized supervision and				
	structure of daily liv	•				
	(2) minimize	the occurrence of behaviors				
	related to functiona					
		fety and deescalate out of				
		cluding frequent crisis				
		or without physical restraint; child or adolescent in the				
	\	ive functioning in self-control,				
		cial and recreational skills; and				
		e child or adolescent in				
		eded to step-down to a less				
	intensive treatment					
		reatment staff secure facility				
		h other individuals and child or adolescent's system				
	of care.	crine of addrescent's system				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL051-151	B. WING	B. WING		R 16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1259 RIE	OGE ROAD			
JNITED	FAMILY NETWORK A	ANGIER	, NC 27501			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE
V 293	Continued From pa	ge 4	V 293			
	This Rule is not me					
		view and interview the facility's ed to coordinate with other	5			
		ne needs for 1 of 3 clients (#1)				
	The findings are:	,				
		• · · · · · · · · · · · · · · · · · · ·				
	Review on 2/9/24 o - admitted 11/30/	f client #1's record revealed:				
		oositional Defiant Disorder &				
	Persistent Depress					
	Review on 2/13/24	of a facility's investigation for				
	client #1 revealed:					
		1/Qualified Professional (QP)				
		tigation on 1/10/24 & 1/23/24 ons alleged a client from siste	r			
		inappropriately touched client				
	#1					
		d client A5 rubbed his leg on				
		ouch his buttocks on another				
	occasion	estigation documented client				
		nformed of the allegations on				
	1/10/24 & 1/23/24	Ŭ				
	Dumin a in tana ina	0/40/04 -15				
	During interview on					
		ial Services guardian reported 1/QP contacted her on 2/7/24	•			
	regarding allegation					

Division of Health Service Regulation STATE FORM

GSNK11

If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
		B. WING		R 02/16/2024		
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
NITED FAMILY NETWORK A	T RIDGE ROAD	GE ROAD				
	ANGIER	NC 27501				
RÉFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 293 Continued From pa	ige 5	V 293				
on him (client #1)" - the Licensee # client touched client - she did not rec regarding the allega During interview on reported: - client #1 allege touched by another away from the facil - measures were - client #1's guar allegations were dis	a 2/13/24 the Licensee #1/QP d he was inappropriately c client at a therapy session ity e put in place after the incident dian was contacted & the scussed tter ways to document how					