

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

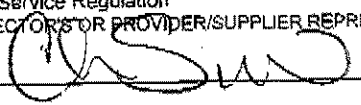
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/16/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on February 16, 2024. The complaint was substantiated Intake #NC00212492. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients & 1 former client.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A. A client will be identified using the letter of the facility and a numerical identifier.</p>	V 000		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <p>(1) technical knowledge;</p> <p>(2) cultural awareness;</p> <p>(3) analytical skills;</p> <p>(4) decision-making;</p>	V 109	<p>V 109</p> <p>It was never stated that anyone was definitively going to jail. It was stated that if behaviors do not change there would be a greater probability of that outcome. Discussions will not be held regarding client's be incarcerated. The state does not want provider to discuss</p>	

Division of Health Service Regulation

LABORATORY DIRECTOR(S) OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X8) DATE 4/03/2024
---	------------------------------------	-------------------------------

STATE FORM 7822 GSNK11 If continuation sheet 1 of 6

Received by MHL & C
4/4/24

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 02/16/2024
NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 109	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 2 Qualified Professionals (QP)/(Licensee #1/QP) demonstrated knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 2/13/24 of the Licensee #1/QP's personnel record revealed: - hired date 10/1/03</p> <p>During interview on 2/9/24 client #1 reported: - the Licensee #1/QP told clients "you going to jail" - it made him mad to hear the Licensee #1/QP say "you going to jail"</p>	V 109	<p>Potentialities of being incarcerated.</p> <p>Chris Simmons will monitor weekly/monthly and as needed. Ongoing.</p> <p>Completed 2/16/2024</p>	

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/16/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 109	<p>Continued From page 2</p> <p>During interview on 2/9/24 client #3 reported:</p> <ul style="list-style-type: none"> - the Licensee #1/QP told clients "you going to jail when you get out of here" - he compared clients with no behaviors to clients that had behaviors - "we go through different problems and should not be compared to each other" <p>During interview on 2/12/24 former client (FC#4)'s Department of Social Services guardian reported:</p> <ul style="list-style-type: none"> - FC#4 informed her the Licensee #1/QP told FC #4, he would end up in jail - there were times the Licensee #1/QP told him during behaviors, he would call the law and he would go to jail - FC#4 informed her the Licensee #1/QP made the comments often - the Licensee #1/QP had told her on visits "the kids will probably end up incarcerated" <p>During interview on 2/13/24 the Licensee #1/QP reported:</p> <ul style="list-style-type: none"> - during group, he discussed the clients' behaviors of stealing & inappropriate touching behaviors - he informed them if they continued with the same behaviors, "they could end up incarcerated" <p>During interview on 2/13/24 the Licensee #2/QP reported:</p> <ul style="list-style-type: none"> - behaviors would be discussed in therapeutic ways 	V 109		
V 293	<p>27G .1701 Residential Tx. Child/Adol - Scope</p> <p>10A NCAC 27G .1701 SCOPE</p> <p>(a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides</p>	V 293		

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/16/2024
--	---	--	--

NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 293	<p>Continued From page 3</p> <p>Intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility.</p> <p>(b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section.</p> <p>(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.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to a community-based residential setting in order to facilitate treatment; and</p> <p>(2) treatment in a staff secure setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) include individualized supervision and structure of daily living;</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p>	V 293	<p>V293</p> <p>Provider consistently provides extensive communication with guardian's and school officials. Allegations were communicated to guardian and incidents were discussed in at least 4 conversations that extended a 30 minute time frame. A text or email will be sent to guardian to follow up/ recap conversations.</p> <p>Chris Simmons will monitor monthly, weekly and as needed ongoing.</p> <p>Completed 2/16/2024</p>	
-------	---	-------	--	--

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/16/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 293	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility's residential staff failed to coordinate with other agencies to meet the needs for 1 of 3 clients (#1). The findings are:</p> <p>Review on 2/9/24 of client #1's record revealed:</p> <ul style="list-style-type: none"> - admitted 11/30/22 - diagnoses: Oppositional Defiant Disorder & Persistent Depressive Disorder <p>Review on 2/13/24 of a facility's investigation for client #1 revealed:</p> <ul style="list-style-type: none"> - the Licensee #1/Qualified Professional (QP) conducted an investigation on 1/10/24 & 1/23/24 - both investigations alleged a client from sister facility A (client A5) inappropriately touched client #1 - client #1 alleged client A5 rubbed his leg on one occasion and touch his buttocks on another occasion - the facility's investigation documented client #1's guardian was informed of the allegations on 1/10/24 & 1/23/24 <p>During interview on 2/12/24 client #1's Department of Social Services guardian reported:</p> <ul style="list-style-type: none"> - the Licensee #1/QP contacted her on 2/7/24 regarding allegations made by client #1 	V 293		
-------	---	-------	--	--

PRINTED: 02/19/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/16/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNITED FAMILY NETWORK AT RIDGE ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 293	<p>Continued From page 5</p> <ul style="list-style-type: none"> - he informed her another client "put his hands on him (client #1)" - the Licensee #1/QP was not clear if the other client touched client #1 physically or sexually - she did not receive an incident report regarding the allegations <p>During interview on 2/13/24 the Licensee #1/QP reported:</p> <ul style="list-style-type: none"> - client #1 alleged he was inappropriately touched by another client at a therapy session away from the facility - measures were put in place after the incident - client #1's guardian was contacted & the allegations were discussed - will develop better ways to document how guardians were notified 	V 293		
-------	--	-------	--	--