PRINTED: 11/12/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	MHL092-708				11/	11/01/2024
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
JNITED	FAMILY NETWORK A	T FUQUAY-VARIN	LTOP TOAD VARINA, NC	27526		
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on 11/1/24. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.					
	census of 1. The su	sed for 4 and has a current urvey sample consisted of client and 1 former client.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, inclustered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the distance of a person of a person of the person of the person of the privileged to prepare (4). 	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications liministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-708			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		11/	11/01/2024	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			01/2024
		5728 HII	LTOP TOAD			
NITED	FAMILY NETWORK A	I FUQUAY-VARIN FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 118	Continued From page 1		V 118			
	checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record re failed to keep MAR The findings are: A. Review on 10/29	et as evidenced by: eview and interview the facility as current for 1 of 1 client (#1). 9/24 of client #1's record				
	(ODD), Attention-D Other Specific Trau Disorder, Disruptive - Physician's ord - Risperidon	old positional Defiant Disorder peficit/Hyperactivity Disorder, uma and Stress Related e Mood Dysregulation Disorder ler dated 9/26/24 revealed: e 1 mg (milligram) take one				
	mouth twice daily (- Physician's ord	e 5 mg take one tablet by				
	MAR revealed: - No staff initials administration for n	4 of client #1's October 2024 that documented norning doses of risperidone 4, 10/11/24, 10/13/24,				

STATE FORM

If continuation sheet 2 of 3

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 11/01/2024	
		MHL092-708				
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JNITED	FAMILY NETWORK A	T FUQUAY-VARIN	LTOP TOAD	27526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 118	Continued From page 2		V 118			
	administration for e from 10/1/24-10/3/2 - No staff initials administration for 1 multivitamin" Interview on 10/29/ - Knew the medi take - Took medication any doses Interviews on 10/29 Licensee/Associate - Staff took MAR to be checked by a including verifying a administration time initials were present - He also checked - He observed st medications were a appropriate adminis - Client #1 "gets day, you can ask hi - Not sure how th October 2024 MAR - Would address Due to the failure to medication adminis	that documented evening doses of aripiprazole 24 that documented 10/26/24 dose of "kids 24 client #1 reported: ication he was supposed to 29 on in morning and at night on every day and never missed 20 client and 11/1/24 e Professional reported: Rs to administrative office daily dministrative assistant, all medications were, as were correct, and staff the MARs monthly taff "periodically" when administered to ensure stration his meds (medication) every				

U6CH11