STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-188	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVIN STINNETT HOME	5401 HAMMERMILL DRIVE HARRISBURG, NC 28075

(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 January 24, 2020. The complaint was substantiated (Intake #NC00157788). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. Multiple facilities and individuals are identified in this report. The licensed facilities are not necessarily sister facilities but may be licensed by four separate licensees. The four licensees will be identified as A, B, C and D. Clients from the licensed facilities will be identified using the letter of the licensed facility and a numerical identifier. Additionally, there are individuals identified in this report who do not reside in licensed facilities. They will be identified by their gender and a numerical identifier.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection 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	V 132		

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V 132	Continued From page 1 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 interview and record review, the facility failed to protect clients during an internal investigation while the investigation was in progress for 2 of 2 staff (Alternative Family Living (AFL) Provider #1 and AFL Provider #2). The findings are: Review on 12/2/2019 of Client #1's record revealed: -Admitted 7/29/2016; -Diagnosed with Autism, Epilepsy, Intellectual Developmental Disability (IDD) Severe, Chronic	V 132		

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V 132	Continued From page 2 Kidney Disease Stage 3, Functional Disorder of the Bladder, Prune Belly Syndrome (characterized by the lack of abdominal muscles), Metabolic Acidosis, Obesity, Lipoma, Hypertension, History of Urinary Tract Infections, Neuromuscular Dysfunction of the Bladder, Benign Lipomatous Neoplasm, Acidosis, Calculus of the Kidney, Proteinuria, Vitamin D Deficiency. Review on 12/2/2019 of Client #2's record revealed: -Admitted 11/1/2019; -Diagnosed with IDD Moderate, Unspecified Psychosis, Attention Deficit Hyperactivity Disorder (ADHD), Schizoaffective Disorder, Impulse Disorder. Review on 12/2/2019 of AFL Provider #1's record revealed: -Hired 7/13/2016. Review on 12/2/2019 of AFL Provider #2's record revealed: -Hired 2/6/2017. Review on 12/17/2019 of the Police Officer/Internal Incident Report dated 11/10/2019 revealed: -Client #1 and Client #2 were located at an unlicensed location (UL) on 10/26/2019 without proper supervision when the police were called to the location for a possible assault. Review on 1/13/2020 of a Level 1 incident report completed for Client #2 attending the UL on 10/26/2019 by AFL Provider #1 dated 11/29/19 revealed: -The UL was used so AFL Provider #1 and AFL Provider #2 could start holiday shopping.	V 132		

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V 132	Continued From page 3 There were no additional incident reports for Client #1 attending the UL on 10/26/2019. Review on 1/13/2020 of Level III Incident Reports completed through North Carolina Incident Response Improvement System (NC IRIS) revealed: -Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family (licensee) first became aware of the incident on 11/21/2019. The report included notification to Healthcare Personnel Registry (HCPR). The incident involved Client #1 being located at an UL without necessary supervision; -Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family first became aware of the incident on 11/21/2019. The report did not include notification to HCPR. The incident involved Client #1 being located at an UL without necessary supervision. Interview on 1/13/2020 with the Qualified Professional revealed: -Discovered the use of UL at the end of November, 2019 at which time she completed a Level I incident report. Interview on 12/2/2019 with the Director of Quality Assurance/Quality Improvement (QA/QI) and the Licensee/Chief Executive Officer (CEO) revealed: -The use of the UL for Client #1 and Client #2 was discovered by the Director of QA/QI and the Licensee/CEO on the morning of 12/2/2019.	V 132		

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V 132	Continued From page 4 Interview on 1/8/2020 with the Director of QA/QI revealed: -As of 1/8/2020, the investigation is on-going and Client #1 and Client #2 remain in the care of AFL Provider #1 and AFL Provider #2; -As of 1/13/2020, the investigation resulted in substantiated findings of neglect against AFL Provider #1 and AFL Provider #2. Client #1 and Client #2 remain in the care of AFL Provider #1 and AFL Provider #2. Despite multiple attempts to obtain a clear timeline, it could not be determined when QP informed Director of QA/QI and Licensee/CEO of the use of the UL. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify the Department within 24 hours of becoming aware of an allegation against health care personnel for 2 of 2 staff (Alternative Family Living (AFL) Provider #1 and AFL Provider #2). The findings are: Review on 12/2/2019 of Client #1's record revealed: -Admitted 7/29/2016; -Diagnosed with Autism, Epilepsy, Intellectual Developmental Disability (IDD) Severe, Chronic Kidney Disease Stage 3, Functional Disorder of the Bladder, Prune Belly Syndrome (characterized by the lack of abdominal muscles), Metabolic Acidosis, Obesity, Lipoma, Hypertension, History of Urinary Tract Infections, Neuromuscular Dysfunction of the Bladder, Benign Lipomatous Neoplasm, Acidosis, Calculus of the Kidney, Proteinuria, Vitamin D Deficiency. Review on 12/2/2019 of Client #2's record revealed: -Admitted 11/1/2019; -Diagnosed with IDD Moderate, Unspecified Psychosis, Attention Deficit Hyperactivity Disorder (ADHD), Schizoaffective Disorder, Impulse Disorder. Review on 12/2/2019 of AFL Provider #1's record revealed: -Hired 7/13/2016. Review on 12/2/2019 of AFL Provider #2's record revealed: -Hired 2/6/2017. Review on 12/17/2019 of the Police Officer/Internal Incident Report dated 11/10/2019	V 318		

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V 318	Continued From page 6	V 318		

revealed:
-Client #1 and Client #2 were located at an unlicensed location (UL) on 10/26/2019 without proper supervision when the police were called to the location for a possible assault.

Review on 1/13/2020 of a Level 1 incident report completed for Client #2 attending the UL on 10/26/2019 by AFL Provider #1 dated 11/29/19 revealed:
-The UL was used so AFL Provider #1 and AFL Provider #2 could start holiday shopping.

There were no additional incident reports for Client #1 attending the UL on 10/26/2019.

Review on 12/20/2019 of North Carolina Incident Response Improvement System (NC IRIS) revealed:
-As of 12/20/2019, there were no incident reports completed regarding Client #1 and Client #2's presence at the UL on 10/26/2019.

Review on 1/13/2020 of Level III Incident Reports completed through NC IRIS revealed:
-Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family (licensee) first became aware of the incident on 11/21/2019. The report included notification to Healthcare Personnel Registry (HCPR). The incident involved Client #1 being located at an UL without necessary supervision;
-Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family first became aware of the

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V 318	Continued From page 7 incident on 11/21/2019. The report did not include notification to HCPR. The incident involved Client #1 being located at an UL without necessary supervision. Interview on 1/13/2020 with the Qualified Professional revealed: -Discovered the use of UL at the end of November, 2019 at which time she completed a Level I incident report. Interview on 12/2/2019 with the Director of Quality Assurance/Quality Improvement (QA/QI) and the Licensee/Chief Executive Officer (CEO) revealed: -The use of the UL for Client #1 and Client #2 was discovered by the Director of QA/QI and the Licensee/CEO on the morning of 12/2/2019. Interview on 1/8/2020 with the Director of QA/QI revealed: -The Level III reports had not yet been entered into NC IRIS as of 1/8/2020 because she was still awaiting direction from the local management entity (LME) on how they should be entered. Despite multiple attempts to obtain a clear timeline, it could not be determined when QP informed Director of QA/QI and Licensee/CEO of the use of the UL. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 8 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367		

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V 367	Continued From page 9 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 10 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level III incident reports to the local management entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 12/2/2019 of Client #1's record revealed: -Admitted 7/29/2016; -Diagnosed with Autism, Epilepsy, Intellectual Developmental Disability (IDD) Severe, Chronic Kidney Disease Stage 3, Functional Disorder of the Bladder, Prune Belly Syndrome (characterized by the lack of abdominal muscles), Metabolic Acidosis, Obesity, Lipoma, Hypertension, History of Urinary Tract Infections, Neuromuscular Dysfunction of the Bladder, Benign Lipomatous Neoplasm, Acidosis, Calculus of the Kidney, Proteinuria, Vitamin D Deficiency. Review on 12/2/2019 of Client #2's record revealed: -Admitted 11/1/2019; -Diagnosed with IDD Moderate, Unspecified Psychosis, Attention Deficit Hyperactivity Disorder (ADHD), Schizoaffective Disorder, Impulse Disorder. Review on 12/17/2019 of the Police Officer/Internal Incident Report dated 11/10/2019 revealed: -Client #1 and Client #2 were located at an unlicensed location (UL) on 10/26/2019 without proper supervision when the police were called to the location for a possible assault.	V 367		

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V 367	Continued From page 11 Review on 1/13/2020 of a Level 1 incident report completed for Client #2 attending the UL on 10/26/2019 by AFL Provider #1 dated 11/29/19 revealed: -The UL was used so AFL Provider #1 and AFL Provider #2 could start holiday shopping. There were no additional incident reports for Client #1 attending the UL on 10/26/2019. Review on 12/20/2019 of North Carolina Incident Response Improvement System (NC IRIS) revealed: -As of 12/20/2019, there were no incident reports completed regarding Client #1 and Client #2's presence at the UL on 10/26/2019. Review on 1/13/2020 of Level III Incident Reports completed through NC IRIS revealed: -Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family (licensee) first became aware of the incident on 11/21/2019. The report included notification to Healthcare Personnel Registry (HCPR). The incident involved Client #1 being located at an UL without necessary supervision; -Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family first became aware of the incident on 11/21/2019. The report did not include notification to HCPR. The incident involved Client #1 being located at an UL without necessary supervision.	V 367		

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V 367	Continued From page 12 Interview on 1/13/2020 with the Qualified Professional revealed: -Discovered the use of UL at the end of November, 2019 at which time she completed a Level I incident report. Interview on 12/2/2019 with the Director of Quality Assurance/Quality Improvement (QA/QI) and the Licensee/Chief Executive Officer (CEO) revealed: -The use of the UL for Client #1 and Client #2 was discovered by the Director of QA/QI and the Licensee/CEO on the morning of 12/2/2019. Interview on 1/8/2020 with the Director of QA/QI revealed: -The Level III reports had not yet been entered into NC IRIS as of 1/8/2020 because she was still awaiting direction from the LME on how they should be entered. Despite multiple attempts to obtain a clear timeline, it could not be determined when QP informed Director of QA/QI and Licensee/CEO of the use of the UL. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC	V 512		

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V 512	Continued From page 13 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on interview and record review, 2 of 2 Alternative Family Living Providers (AFL Provider #1 and AFL Provider #2) neglected 2 of 3 clients (Client #1 and Client #2). Furthermore, 3 of 3 Qualified Professionals (Licensee/Chief Executive Officer (CEO), Director of Quality Assurance/Quality Improvement (QA/QI), Qualified Professional QP)) failed to protect 2 of 3 clients (Client #1 and Client #2) from neglect. The findings are: CROSS REFERENCE: General Statute 131E-256 Health Care Personnel Registry (V132). Based on interview and record review, the facility failed to protect clients during an internal investigation while the investigation was in progress for 2 of 2 staff (Alternative Family Living (AFL) Provider #1 and AFL Provider #2).	V 512		

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V 512	Continued From page 14 CROSS REFERENCE: 10A NCAC 130 .0102 Investigating and Reporting Health Care Personnel (V318). Based on interview and record review, the facility failed to notify the Department within 24 hours of becoming aware of an allegation against health care personnel for 2 of 2 staff (Alternative Family Living (AFL) Provider #1 and AFL Provider #2). CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on interview and record review, the facility failed to report all Level III incident reports to the local management entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. Review on 12/2/2019 of Client #1's record revealed: -Admitted 7/29/2016; -Diagnosed with Autism, Epilepsy, Intellectual Developmental Disability (IDD) Severe, Chronic Kidney Disease Stage 3, Functional Disorder of the Bladder, Prune Belly Syndrome (characterized by the lack of abdominal muscles), Metabolic Acidosis, Obesity, Lipoma, Hypertension, History of Urinary Tract Infections, Neuromuscular Dysfunction of the Bladder, Benign Lipomatous Neoplasm, Acidosis, Calculus of the Kidney, Proteinuria, Vitamin D Deficiency; -Physician's orders dated 3/25/2019 and October, 2019 Medication Administration Record (MAR) revealed Client #1's medications: -Lisinopril (blood pressure control) 20 milligrams (mg) 1 tablet (tab) at 8am; -Felbamate (seizure control) 600mg/5milliliter (ml) suspension take 7ml at 8am, 12pm, 4pm, and 8pm;	V 512		

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V 512	Continued From page 15 -Tricitrates Potassium Citrate-Sodium Citrate-Citric solution (kidney stone prevention) take 12.5ml at 8am, 12pm, and 8pm; -Vimpat (seizure control) 10mg/ml solution take 3 teaspoons at 8am and 8pm; -Lamotrigine (seizure control) 100mg tab take three tabs at 8am and 4 tabs at 8pm; -Thorazine (anti-psychotic) 50mg tab take 2 tabs at 1pm and take 1 tab at 8pm; -Diastat AcuDial (seizure control) 12.5-15-20 Insert 20mg rectally as need for seizure activity longer than five minutes or clusters of seizures; -Medications were administered daily by the AFL Providers. -Treatment plan dated 9/1/19 revealed respite services were to be arranged and provided by Still Family. " ...[Client #1] does not have the ability to control his anger ...has engaged in hitting, kicking, and property destruction ...needs intervention and the training of relevant persons to implement specific interventions ...requires support in communicating, staying safe in the home and community, self-care, activities of daily living, household tasks, transportation, medical, ...support to manage a medical or health condition, nutrition, health screening/preventative care ...need a structured daily routine ...struggles with socialization ...and speech ...;" -Risk/Support Needs Assessment dated 3/25/2019 revealed " ...[Client #1] must have his meats chopped up into nickle size pieces as he will try to swallow food without chewing properly ...RISK of choking due to not chewing his food properly ...[Client #1] requires transitional verbal prompting from staff and redirection to prevent aggressive outburst. [Client #1] requires transitional timing to assist him in preparing for the next activity. [Client #1] will need to be verbally coached out of an area if he becomes extremely aggressive. He must know in advance	V 512		

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if there is any change in schedule ....He does not like surprises. Staff must watch [Client #1] and his eyes. If he lowers his head and looks at someone, he is frustrated with that person and may strike out ..." Client #1 is unable to regulate water temperature, is at high risk of wandering away, is unable to prevent victimization in the home or community, unable to evacuate in event of a fire, and requires support to access help in emergencies. Client #1 requires 24-hour supervision to ensure safety and is not allowed to remain in the home or community alone.

Review on 12/2/2019 of Client #2's record revealed:
-Admitted 11/1/2019;
-Diagnosed with IDD Moderate, Unspecified Psychosis, Attention Deficit Hyperactivity Disorder (ADHD), Schizoaffective Disorder, Impulse Disorder;
-Physician's orders dated 4/3/2019 and October, 2019 MAR revealed Client #2's medications:
-Benzoyl Peroxide (treatment of skin condition) 10% wash at 8pm;
-Clindamycin (treatment of skin condition) 1% gel to affected areas at 8am and 8pm;
-Concerta ER (Extended Release) (treatment of ADHD) 36mg 2 tabs at 8am and 8pm;
-Lorazepam (reduce agitation) 1mg 1 tab at 8am and 2 tabs at 8pm;
-Quetiapine Fumarate (mood stabilizer) 300mg 1 tab at 8am and 8pm;
-Vitamin D3 (supplement) 1,000-unit soft gel 1 capsule at 8am and 8pm;
-Vitamin E (supplement) 1,000-unit capsule at 8am;
-Clonidine HCL (treatment of ADHD) 0.1mg 2 tabs at 8am and 1 tab at 2pm;
-Divalproex Sodium ER (mood stabilizer)

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500mg 1 tab at 8am and 2 tabs at 6pm;
-Folic Acid (supplement) 1mg 1 tab at 8am;
-Levothyroxine (treatment of thyroid condition) 50 micrograms (mcg) 1 tab at 8am;
-Medications were administered daily by the AFL Providers;
-Treatment plan dated 8/1/2019 revealed respite services were to be arranged and provided by Still Family. Client #2 has a history of aggression and property destruction, " ...may hit, pinch and kick others ...kick holes in the walls, break objects ...tease, yell and swear ...threaten to harm others ...have a difficult time transitioning ...will touch self inappropriately in public if not monitored ...love being around females, but do not understand boundaries, appropriate interactions and personal space with them ...make unwelcomed sexual comments and advances...do not recognize the difference between an adult female and underaged girls and may approach them as well...require supports ...to ensure [Client #2] remains socially appropriate ..."
-Risk/Support Needs Assessment dated 2/14/2019 revealed " ...requires support due to inability to make safe choices ...support to prevent victimization ...support to evacuate the home in event of the fire ...support to access help in emergencies ..." Client #1 requires 24-hour supervision to ensure safety and is not allowed to remain in the home or community alone.

Review on 12/2/2019 of Client #A1's record revealed:
-Diagnosed with Unspecified Mood Disorder, Autism, ADHD, Phonological Disorder.

Review on 12/2/2019 of Client #A2's record revealed:
-Diagnosed with Hirschsprung's Disease

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(condition that involved missing nerve cells in the muscles of the large intestine resulting in difficulty passing stools), IDD Severe, Ileostomy, Epilepsy, Cerebral Palsy, Disease of the Urinary System, Enterocolitis, Aphasia.

Review on 12/2/2019 of Client #B1's record revealed:
-Diagnosed with IDD Moderate, Bipolar Disorder, Obesity, Hypertension, Hypothyroidism, Vitamin D Deficiency, Conduct Disorder.

Review on 12/2/2019 of Client #B2's record revealed:
-Diagnosed with IDD Severe, ADHD, Bipolar Disorder, Hypertension, Paroxysmal Tachycardia.

Review on 12/3/2019 of Client #C1's record revealed:
-Diagnosed with ADHD, Mood Disorder, IDD Mild, Oppositional Defiant Disorder (ODD), Impulse Control Disorder, Intermittent Explosive Disorder, Type 2 Diabetes, Asthma, Bilateral Myopia.

Review on 12/17/2019 of the Police Officer/Internal Incident Report dated 11/10/2019 revealed:
-On Saturday, 10/26/2019 at approximately 1:40pm, the officer was dispatched to check on the welfare of a 20-year-old female (Female #1) with special needs who was on the front porch of Community Member #1 (CM #1)'s home. Female #1 alleged she was assaulted but did not have any visible signs of injury. Female #1 was from a home (Unlicensed Location (UL)) located across the street from CM #1's home. Female #1 " ...became agitated and upset when the caretakers approached her ..." Upon further investigation it was determined Female #1 was not assaulted. The UL housed " ...approximately

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V 512	Continued From page 19 8 individuals with special needs and 2 caretakers (Caretaker #3 and Caretaker #4) in the residence ..." when local law enforcement entered the UL; -There were 11 individuals named in the 10/26/2019 local law enforcement report, 7 were from mental health facilities licensed by Division of Health Service Regulation (DHSR): -2 clients from Still Family (Licensee); -2 clients from Licensee A; -2 clients from Licensee B; -1 client from Licensee C; -" ...[CM #1] stated that [Female #1] came over to her house from [UL] and stated to her that she was beaten with a belt. [Female #1] refused to leave the front porch of [CM #1's home] due to being in fear of her care givers at [UL]. [CM #1] went on to say that when the care givers came over to retrieve [Female #1] she became even more upset and despondent at the mere sight of the two care givers ...[CM #1] and [CM #2] both said that they don't know what was going on at [UL], but it is very strange. They said that a different group of kids gets dropped off at the house every Friday and then picked back up on Monday. Between Friday and Monday the kids wander the neighborhood unsupervised, trying to get into other peoples residents, ringing their door bells, banging on doors and there is a lot of screaming that happens in the house ...Upon entering the [UL] there was a small office space to the left in the foyer that had an inflatable mattress in it and had a curtain attached to a shower curtain rod that covered the doorway. The dining room was to the right. Further inside you passed a door that lead to stairs going downstairs. You then passed a set of stairs to the left that went upstairs. The next room you entered was the den/family room. There were 6 subjects seated in this room on couches watching a movie. All subjects had physical characteristics	V 512		

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of having some form of a mental or physical handicap, a few were non-verbal. The attached kitchen was cluttered with dirty dishes and both rooms were overcrowded with personal affects and furniture ...the bedroom at the top of the stairs to the right had the door handle tethered to the banister so no one could come or go from this room. Inside the room was [Male #2]. According to [Caretaker #3], the door was tethered to the banister so [Male #2] could not come out of his/her room and fall down the stairs. [Male #2] is also non-verbal. [Male #2] was asleep the entire time we were inside the house. There was human feces on the walls and ceiling and the room smelled like human urine. The next room down the upstairs hallway on the left appeared to be a master bedroom. There was a king size bed, an extra headboard, a couch and access to a private bathroom. Inside the room there was an IV (intravenous) bag pegged to the wall with drip lines hanging down to the floor. There were several IV solution bags with an unknown fluid inside on a dresser along with medication bottles belonging to different people. The couch was made up as a bed with pillows and blankets. Further down the upstairs hallway to the right was a bathroom. The next room after the bathroom was over the garage. This is where we found a small amount of marijuana and pill bottles belonging to [Client #A2] and [Caretaker #3]. There was a queen size bed in this room. While in this room a young black female walked out of an adjacent bedroom. The female identified herself as [Caretaker #3's child] (13 years-old). She said that she lives at this address with her mom. The room that [Caretaker #3's child] came out of did not have a mattress or even an inflatable mattress. There was a king or queen size mattress leaning up against the wall in the hallway. Not sure what room it belonged in. After

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clearing the upstairs I walked down to the main floor and then took the interior staircase down to the basement. The basement had two couches, a pool table, an inflatable mattress on the floor and an additional room off to the side. The additional room appears to have just been framed in with no sheet rock over the 2x4 studs that framed the room. In the middle of the room was a hospital grade bed that was plugged into a wall socket and an inflatable mattress on the floor next to the bed. It also appeared that this room was being used as storage ...The fire marshal said that the house needed to be shut down as a medical care facility and all occupants who were receiving care needed to be taken to either the hospital or have their primary care guardian come pick them up. We asked [Caretaker #3] for each of the occupants contact information and she said that she did not have it. She said that [Caretaker #1] who is the primary person over the house and its functions has all of that information. So I clarified that there were no medical files on site for any of the mentally handicapped people inside the house and she said that there was not. [Caretaker #3] did not have any contact information for the subjects. The only thing she had to know who they were, were their medical prescriptions. We asked [Caretaker #3] to call [Caretaker #1] and have him come back to the house. She said that she did and that it was going to take [Caretaker #1] an hour to get there. Some of the subjects on site could communicate with us, so we were able to get basic information from some of the occupants. Others were non-verbal and we could not communicate with them ...[Client #A1 and Client #C1] ...both said that they are part of an AFL, Alternative Family Living group and that on the weekends they come to this house to give their primary care givers a break. They arrive on Friday and leave on

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V 512	Continued From page 22 Monday. This information corroborated what the neighbors (CM #1 and CM #2) had told me when I first arrived. They said that they sometimes get picked up by someone else and taken places for fun to get out of the house. Coincidently I had seen both [Client #A1 and Client #C1] at a fall festival I was working at the [local]apartment complex. They arrived back at the house in the company of [Caretaker #5] who said he volunteers his time to assist with this organization. Approximately an hour and half after we had asked [Caretaker #3] to call [Caretaker #1] to return back to the house. He arrived with [Caretaker #2] and a male individual (Male #3). [Caretaker #1 and Caretaker #2] are renters (of the house). [Caretaker #1] said that he has obtained the necessary certifications to act as a Mental Health Professional, or QP. [Caretaker #3] said that he is not operating a business, does not have an LLC (Limited Liability Corporation), but gets paid in cash by the primary care givers who drop their adult off at the house on the weekends. He said that [Caretaker #3] does work for him and he maintains a 1 to 5 ratio of care giver to occupant. He works with local organizations but primarily gets his clients by work of mouth. He said that this is operating in a gray area of local zoning and residential care facility guidelines that does not require him to maintain a license of operation for caring for mentally and physically handicapped people. He said that this is just a temporary care place used only on the weekends and that none of the handicapped subjects live here. [Caretaker #1] kept using the word "we" when describing what he was doing and how he was doing it. As it seems there is a larger network of people who are involved in this type of operation/business. He does not maintain any medical records on site, but keeps everything on his phone. When I	V 512		

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V 512	Continued From page 23 asked about how medication is given, he said it's based on what ever the bottle says. I asked about the IV that was pegged to the wall in the master bedroom and he said that [Caretaker #3] and [Caretaker #2] have medical training to start and administer IV fluids. [Caretaker #2] said that she used to be a medic, but did not say where. The house was described as a "Respite" location for primary care givers...While walking through the house I found several pieces of mail from the IRS (Internal Revenue Service) and Department of Treasury addressed to [Caretaker #2] and [Unknown Male]. While completing this report I found that [Caretaker #2] has an outstanding warrant out of [Local State] for traffic offenses and [Caretaker #1] NCDL (North Carolina Driver's License) is suspended. The warrant for [Caretaker #2] is non-extraditable outside the state of [Local State] ...this case was referred to Department of Social Services, Adult Protective Services, and Department of Health and Human Services ...from a criminal stand point ...we could not charge the listed suspects. The suspect [Caretaker #1] is operating a respite care facility for adults who live in Alternative Family Living Situations. It is not a licensed facility, he does not advertise for it and all clients are all through word of mouth. The house is a rental property. Given the circumstances surrounding this case, I visited the homeowner who went to check on the house. The homeowner was under the impression that there would only be one or two AFL adults staying at the house, not 11. The homeowner is having the suspects move out and is putting the house up for sale ...the [UL] did not meet basic fire code standards. Given the victim's mental handicap's it posed a serious and potential life threating environment ..." Review on 12/17/2019 of the Investigative Report	V 512		

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V 512	Continued From page 24 dated 10/26/2019 by the county's Fire Marshall Office regarding the UL revealed: -" ...found conditions in the home that posed fire and life safety concerns ...there were multiple special needs adults staying in the home and that there were mattresses everywhere, smoke alarms had been taken down throughout the home, and that one of the occupants was found sleeping in a 2nd floor bedroom with the bedroom door pulled shut and tied to a stair post, trapping the occupant in the room ...the dwelling is a rental property occupied by [Caretaker #1] and [Caretaker #2] ...this investigator entered the home and observed several adults watching television in the living room. A female later identified as [Caretaker #3] informed that she was a care giver and was a Certified Nursing Assistant (CNA) affiliated with [Licensee A] ...[Caretaker #3] informed that she resides at these premises and cares for several special needs adults that are dropped off for one or two days over the weekend in order to provide some relief to their permanent care givers, suggesting that this was some type of respite care facility. [Caretaker #3] also informed that the couple that operated this business were not home ...Upon entering the front entry foyer, this investigator observed what appeared to be an office room located just off the left of the main entry. This room had a black curtain that was partially drawn to provide privacy. A mattress was observed on the floor of this room. This investigator then entered the attached garage and observed general storage and other items within this space. Access to the electrical service panel was obstructed with the storage accumulations. This investigator proceeded back to the main entry foyer of the home and observed a glass panel door leading to the basement of the home. This door opened inward towards the basement stairs and was found that have both a	V 512		

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(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
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locking door knob and dead-bolt lock. The door was found unlocked and open at the time of this investigation but could be locked and secured from the egress side, thus preventing occupants in the basement from accessing the main floor of the home. This investigator proceeded down to the basement and noted that the basement was partially finished space. This investigator observed that the hardwired smoke alarm located on the ceiling of the basement hall had been removed, with exposed wiring harness hanging out of the installation base. Turning towards the basement exit door leading to lower grade exterior at the rear of the home, this investigator observed that this door had (2) locks, one of which was a double-sided key lock, requiring the use of a key to unlock this door from the egress side. A key for this door was not found in the area of the door thus an occupant trying to escape would require a key and/or special knowledge to unlock this door. This investigator observed what appeared to be a framed out unfinished space/area towards the front of the home in the basement. A medical type bed and inflatable mattress were noted in this space. There was no smoke alarm noted in this space/area. A bedroom with (2) box springs and mattresses was observed in the basement. The hardwired smoke alarm had also been removed from this bedroom. This investigator then proceeded to the 2nd floor of the home and observed an open door just to the right of the stairs, with what appeared to be a belt from a robe secured to this inside of the door. The door knob was missing from the front side of this door. This investigator observed that this was a bedroom with a sleeping occupant ...[Local Firefighter] informed this investigator that when he first came up the stairs to the 2nd floor he found this belt tied around the stair post securing

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V 512	Continued From page 26 this door shut and preventing the sleeping occupant found in this bedroom from escaping in case of fire or emergency. [Local Firefighter] had untied the belt to access the bedroom where the sleeping occupant was found ...Upon entering this room, this investigator observed a mattress and box spring on the floor, as well as a bed with a sleeping occupant on it. Additional bedding was observed on the floor next to the bed. This investigator observed what appeared to be human waste on the ceiling and walls in this bedroom, as well as a missing hardwired smoke alarm. Proceeding into another bedroom on the 2nd floor, (possibly the master bedroom), this investigator observed an unmade bed with an intravenous (IV) bag hanging from the wall on the left side of the bed. The hardwired smoke alarm had also been removed from this bedroom. Additional bedrooms were found on the 2nd floor, but one of these appeared to be a converted attic space, with non-conforming door opening. Stepping into this room, this investigator observed a typical bedroom set-up with several medication containers on the bed. This investigator did not disturb these medication containers but simply photographed them in place. The hardwired smoke alarm had been removed from this bedroom ...it is the opinion of this investigator that this single-family dwelling occupancy use has been changed. The home has been improperly converted without required permits or approvals and is currently being used to house adult clients with special needs, suggesting some type of respite care operation. It is further the opinion of this investigator that conditions found within these premises pose an immediate fire and life safety risk to occupants. The absence or removal of required hardwired interconnected smoke alarms throughout directly impacts the safety of the occupants, especially	V 512		

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V 512	Continued From page 27 when sleeping, as they would not receive early notification of smoke or fire in the home. Additionally, securing the 2nd floor bedroom door by tying it off to the stair post would trap the occupant(s) within this bedroom, leaving only the window as a possible means of escape in case of smoke or fire. This would also impede fire department fire suppression and rescue efforts. The keyed locks found on the door connecting the basement with the main level of the home, as well as the basement exit door leading to exterior grade at the rear of the home impede occupant egress and require additional effort or special knowledge by the occupant(s) trying to escape a fire or other emergency. The sleeping room/area that has been framed out in the basement does not have required opening for fire/rescue or escape, thus the occupant(s) could be trapped in this space ...In order to prevent injury or death to occupants or clients temporarily being house in these premises, this investigator has issued an immediate evacuation order ...building deemed unsafe ....has hazardous conditions that present imminent danger to building occupants ...." Review on 1/14/2020 of investigating local law enforcement officer's body camera video dated 10/26/2019 and the still photographs taken by the Fire Marshall dated 10/26/2019 revealed: -CM #1 and CM #2 reported Female #1 ran from the UL reporting she was "beat with a belt;" -CM #1 and CM #2 reported the caretakers at the UL "let them run loose," wander into yards, and they hear "crazy noises" at night from the UL. The individuals stay at the UL from Friday night until Monday morning; -Officer requested permission to enter the UL which was granted by Caretaker #3; -Multiple household items cluttered countertops leaving no bare surface area;	V 512		

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-Multiple personal items cluttered floors throughout the home;
-Bare mattress leaned against walls in hallway;
-Bare framing 2x4 studs in the basement room housed one twin hospital bed with a black plastic mattress with a white fitted sheet in the center of the mattress rolled in a ball. Next to the hospital bed was a twin, uninflated blow-up mattress without a sheet. The floor to the room was a concrete slab. There were electrical cords draped across the room leading from the hospital bed and uninflated blow-up mattress to an exposed outlet;
-Human fecal matter smeared on the walls and ceiling of an upstairs bedroom;
-Cloth belt or strip of fabric used to tie a bedroom door to the handrail;
-IV bags pegged to the wall of one bedroom;
-Worn, dirty, and ripped furniture throughout the home;
-Open and uncovered electrical panel;
-Multiple medication bottles for Client #A2 left visible on a bed;
-Caretaker #5 arguing with law enforcement and fire officials that they had no right to enter the UL.

Review on 1/14/2020 of the local law enforcement's call report for the UL from 1/1/2019 through 1/14/2020 revealed:
-8/26/2019: Check the welfare;
-9/1/2019: Check the welfare;
-10/26/2019: Check the welfare;
-10/29/2019: Follow up of 10/26/2019 calls.

Review on 12/2/2019 of AFL Provider #1's record revealed:
-Hired 7/13/2016;
-Job description signed 7/27/2016 revealed " ...position responsibilities: completion of duties and the implementation of various skill building

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activities per participant's individualized Plan of Care (treatment plan) ...implement therapeutic monitoring ...completes incident reports per occurrence ...reports to QP any concerns or problems either employee or participant related ...;"
-Medication administration training completed 8/26/2019.

Review on 12/2/2019 of AFL Provider #2's record revealed:
-Hired 2/6/2017;
-Job description signed 2/6/2017 revealed " ...position responsibilities: completion of duties and the implementation of various skill building activities per participant's individualized Plan of Care (treatment plan) ...implement therapeutic monitoring ...completes incident reports per occurrence ...reports to QP any concerns or problems either employee or participant related ...;"
-Medication administration training completed 10/10/2019.

Review on 12/2/2019 and 1/13/2020 of QP's record revealed
-Hired 8/15/2019;
-Job description signed 9/3/2019 revealed " ...position responsibilities: serve as an advocate for the individual ..."

Review on 12/2/2019 of the Director of QA/QI revealed:
-Hired 8/31/2017.

Review on 12/2/2019 of the Licensee/Chief Executive Officer's (CEO) record revealed:
-Hired 2005.

Review on 1/13/2020 of a Level 1 incident report

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completed for Client #2 attending the UL on 10/26/2019 by AFL Provider #1 dated 11/29/19 revealed:
-" ...Around 11am [Client #2] was picked up by [unidentified caretaker]. We (AFL Provider #1 and AFL Provider #2) sent [Client #2] to enjoy social time with his peers so we can start our Christmas shopping. Around 2pm we received the call from the [unidentified caretaker] saying that the police were called to a private home in [local town] and that [Client #2's] name was taken in the incident but he had nothing to do with the physical situation there. It was reported to us that [unidentified caretaker] was stopping by this house in [local town] to pick up to other members to attend [UL]. At that time there was a physical altercation between members of this house. We immediately requested the address and went to pick up [Client #2]. [AFL Provider #1] contacted [QP] on 11/21/2019 reporting an incident that took place with [Client #2]. [AFL Provider #1] reported that he dropped [Client #2] off at [UL]. [AFL Provider #1] continued to say that they (AFL Provider #1 and AFL Provider #2) received a call stating that [Client #2] was a house that the police was called out to. [AFL Provider #1] continued to report that he was told that the police were called out because someone in that house was having behaviors. [AFL provider #1] stated that [Client #2's] guardian questioned him about this incident. [AFL Provider #1] denied that [Client #2] was at [UL]. [AFL Provider #1] denied that [Client #2] was at the house involving the police. [AFL Provider #1] stated that he initially lied because he was scared that he was going to get in trouble because he didn't permission from the guardian to take [Client #2] to [UL]. [AFL Provider #1] told me that the guardian question him again when she got the police report and he told her the truth that he did take [Client #2] to [UL] and that he

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was at the house. [AFL Provider #1] also told me that he explained to [Client #2's] guardian the reason he didn't tell the truth in the beginning, which was due to being scared of the trouble he would get in for not getting permission for [Client #2] to attend [UL] ..."

There were no additional incident reports for Client #1 attending the UL on 10/26/2019.

Review on 12/20/2019 and 1/13/2020 of North Carolina Incident Response Improvement System revealed:
-As of 12/20/2019, there were no incident reports completed regarding Client #1 and Client #2 presence at the UL on 10/26/2019;
-Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family first became aware of the incident on 11/21/2019. The report included notification to HCPR. The incident involved Client #1 being located at an UL without necessary supervision;
-Incident report dated 1/9/2020 regarding an allegation of neglect involving Client #1 against AFL Provider #1 and AFL Provider #2. The incident occurred on 10/26/2019. The report indicated Still Family first became aware of the incident on 11/21/2019. The report did not include notification to HCPR. The incident involved Client #1 being located at an UL without necessary supervision.

Review on 1/13/2020 of the undated Internal Investigation completed by the Director of QA/QI regarding the 10/26/2019 incident involving Client #1 and Client #2 at an UL revealed:
-" ...Summary of findings/facts ...[AFL Provider

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V 512	Continued From page 32 #1] did not get permission from the guardian of [Client #2] to attend [UL]. [AFL provider #1] lied on multiple occasions regarding the incident. [AFL Provider #2] lied on multiple occasions regarding the incident. [AFL Provider #1] allowed an unauthorized person to drive the members around. [AFL Provider #1] left the members in the care of an unauthorized person ...Based on this investigation it has been determined: The allegation of neglect is substantiated. [AFL Provider #1] did not ensure the safety of [Client #1] and [Client #2] by allowing an unauthorized person to transport them and leaving them in the care of unauthorized person/s on three separate occasions ...Corrective action ...[AFL Provider #1] will refund any money used to pay [UL] to the members (Client #1 and Client #2). The members in the home (AFL facility) will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. No member will attend [UL]. [AFL Provider #1] and [AFL Provider #2] will be retrained on the residential service definition. [AFL Provider #1] and [AFL Provider #2] will receive disciplinary action (final written warning) with any further infractions terminating the license and separating from the agency (licensee)..." Interview on 1/9/2020 with Client #1 revealed: -Knew Caretaker #1 but could not provide specifics on how. Attempted interview on 1/13/2020 with Client #1's Legal Guardian/Mother was unsuccessful. A phone message was left requesting a return phone call, but no return phone call was ever received. Interview on 1/9/2020 with Client #2 revealed: -Caretaker #1 picked him up at his AFL home;	V 512		

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V 512	Continued From page 33 -Spent time with his friends while at the UL; -Enjoyed spending time with Client #C1 while at the UL; -An unidentified female ran out of the UL and local law enforcement arrived; -Did not know the female's name; -Caretaker #1 was somewhere else when the female ran out of the UL; -Sometimes would only spend the afternoon at the UL; -Slept at the UL twice; -Slept on the couch while at the UL; -Caretaker #1 would give Client #2 medication when Client #2 was at the UL. Interview on 1/8/2020 with Client #2's Department of Social Services (DSS) Legal Guardian revealed: -Was notified through a local neighboring Adult Protective Service (APS) office that Client #2 was found with other individuals with IDD at an UL in late October, 2019; -Was not aware Client #2 was at the UL and did not grant consent for the use of the UL; -Client #2 had no home or community alone time; -Contacted Still Family with questions regarding the specifics of Client #2's respite services; -AFL Provider #1 and AFL Provider #2 initially reported Client #1 and Client #2 were at the movies on 10/26/2019; -The investigating officer reviewed video surveillance footage of the movie theater allegedly visited by Client #1 and Client #2 and determined Client #1 and Client #2 were never at the theater on 10/26/2019; -On 11/20/2019, along with investigating police officer, confronted AFL Provider #1 and AFL Provider #2 regarding Client #2's presence at the UL after an extensive investigation; -On 11/26/2019, AFL Provider #1 and AFL	V 512		

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V 512	Continued From page 34 Provider #2 admitted Client #1 and Client #2 were at the UL on 10/26/2019; -On 11/27/2019, notified the local management entity (LME) regarding AFL Provider #1 and AFL Provider #2 admitting, after multiple conversations, that they initially lied about their reports of Client #2's presence at the UL on 10/26/2019; -Was planning on moving Client #2 from the AFL facility. Interview on 1/9/2020 with AFL Provider #1 revealed: -Had met Caretaker #1 years ago through a weekend program provided by Licensee A; -Ran into Caretaker #1 in Spring, 2019 and was informed by Caretaker #1 he was providing weekend services and offered transportation; -Decided to use Caretaker #1 for services on the weekend for Client #1 and Client #2; -Client #1's legal guardian was aware of Client #1 spending time with Caretaker #1, but Client #2's legal guardian was not aware of Client #2 spending time with Caretaker #1; -Received a call at the end of October, 2019 because the police had arrived at the UL and AFL Provider #1 was asked to pick up Client #1 and Client #2; -Caretaker #1 explained to AFL Provider #1 that Client #1 and Client #2 were at Caretaker #1's home (UL) as Caretaker #1 had to stop and get something at his house while he had Client #1 and Client #2 in his care; -Client #2's DSS legal guardian had been notified of the police arrival at the UL and had not granted permission for Client #2 to be with Caretaker #1; -AFL Provider #1 grew concerned when Client #2's DSS legal guardian investigated the placement of Client #2 at the UL and AFL Provider #1 lied about Client #2 being at the UL	V 512		

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V 512	Continued From page 35 on 10/26/2019; -AFL Provider #1 went to pick up Client #1 and Client #2 from the UL on 10/26/2019. When AFL Provider #1 got to the UL, the police were gone. The door of the UL opened and Client #1 and Client #2 walked out; -Caretaker #1 never offered any explanation or answered any questions regarding the incident; -"There is no blame but mine, because they (Client #1 and Client #2) were in my care." Interview on 1/9/2020 with AFL Provider #2 revealed: -AFL Provider #1 met Caretaker #1 years ago through a weekend program provided by Licensee A; -AFL Provider #1 ran into Caretaker #1 in Spring, 2019 and was informed by Caretaker #1 he was providing weekend services and offered transportation; -Decided to use Caretaker #1 for services on the weekend for Client #1 and Client #2; -Client #1's legal guardian was aware of Client #1 spending time with Caretaker #1, but Client #2's legal guardian was not aware of Client #2 spending time with Caretaker #1; -Repeatedly asked Caretaker #1 for guardian consent papers for Client #2; -Caretaker #1 picked Client #1 and Client #2 up from the AFL facility after lunch and would return them around 6:30pm or 7:00pm on some Saturdays; -Client #1 and Client #2 did not spend any overnight visits with Caretaker #1; -AFL Provider #1 received a call from Caretaker #1 on 10/26/2019 when Caretaker #1 was on the road picking up another client; -Caretaker #1 informed AFL Provider #1 the police were at the UL and Caretaker #1 had already dropped Client #1 and Client #2 at the	V 512		

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UL;
-Caretaker #1 normally provided transportation back and forth to the UL;
-AFL Provider #1 went to pick up Client #1 and Client #2 from the UL on 10/26/2019;
-AFL Provider #1 and AFL Provider #2 were not aware that Caretaker #1 had a suspended driver's license;
-Paid $30 in cash for each client to spend afternoons at the UL;
-AFL Provider #2 "did not do due diligence" in researching the UL.

Interview on 1/13/2020 with the QP revealed:
-Started QP duties at the AFL facility in September, 2019;
-Respite services for Still Family involved the use of pre-trained, pre-approved providers and not the use of outside resources;
-The UL was not on the list of respite providers for Still Family;
-Was not aware the UL was used for respite services until the end of November, 2019;
-Client #2's DSS legal guardian is considering moving Client #2 to another home due to the incident involving the use of the UL;
-Client #1 was not being considered for a move from the AFL facility;

Interview on 12/2/2019, 1/8/2020, 1/13/2020, and 1/24/2020 with the Director of QA/QI revealed:
-The use of the UL for Client #1 and Client #2 was only brought to the attention of The Director of QA/QI and the Licensee/CEO on the morning of 12/2/2019;
-Had completed the internal investigation on 1/12/2020 regarding the presence of Client #1 and Client #2 at the UL;
-The Level III reports had not yet been entered into North Carolina Incident Response

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Improvement System (NC IRIS) on 1/8/2020 because she was still awaiting direction from the LME on how they should be entered;
-Was unable to complete the Healthcare Personnel Registry (HCPR) section on Client #2's Level III incident report in NC IRIS regarding the alleged staff because the LME closed the incident so quickly. Had not called the LME to add the HCPR information. Furthermore, there was no information submitted directly to HCPR;
-After multiple attempts to provide an acceptable Plan of Protection to DHSR (Division of Health Service Regulation), the decision was made to close the AFL facility and surrender the DHSR mental health license.

Interview on 12/2/2019 and 1/8/2020 with the Licensee/CEO revealed:
-The use of the UL for Client #1 and Client #2 was only brought to the attention of The Director of QA/QI and the Licensee/CEO on the morning of 12/2/2019;
-Continued investigation into the incident involving Client #1 and Client #2's presence at the UL was on-going.

Interview on 1/15/2020 with Client #A1 revealed:
-Spent time with Caretaker #1 at the UL;
-Caretaker #1 picked him and Client #A2 up from their AFL facility;
-Went to a football game with Client #C1 with one of Caretaker #1's helpers;
-Local law enforcement was present at Caretaker #1's UL when Client #C1 and Client #A1 returned to the UL (October, 2019);
-Local law enforcement had arrived because a girl had run away and said she was hit with a belt;
-Did not believe the girl was hit with a belt;
-Did not remember the girl's name;
-Local law enforcement went upstairs and saw a

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"really disabled guy ...who wiped [feces] on the wall and [feces] was left there." He was approximately 16 years old and went to a "special school" in the local city;
-Took medication at the UL and believed the medication was "given to me appropriately" by the caretakes of the UL, but could not identify the names of his medications or the details of medication administration;
-Slept on the couch at the UL "because a lot of spaces were full;"
-Different people slept in the partially finished basement, but he slept near the kitchen;
-Knew Client #B1 and Client #B2 because they attended the UL every few weeks;
-Went to the UL frequently;
-The UL cost $100 per weekend;
-Client #A2 went to the UL, spent the entire weekend, and slept in a bed upstairs;
-There were staff at the UL, but he could not identify the staff by name;
-Client #1 and Client #2 would attend the UL but would not go every weekend. They started by visiting and then spent nights;
-Client #1 and Client #2 slept downstairs when they spent the whole weekend at the UL;
-Client #C1 slept on the living room couch, or the recliner, or shared the living room couch with Client #A1;
-Male #3 is a "disabled older man with a walker" who spent time at the UL;
-Male #4 also slept at the UL;
-Missed seeing his friend, Client #C1, who went to the UL every weekend.

Attempted interview on 1/15/2020 with Client #A2 was unsuccessful as Client #A2 was non-verbal.

Interview on 12/4/2019 with Client #B1 revealed:
-Was picked up by Caretaker #1 to attend the

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"bed and breakfast" at the UL along with Client #B2;
-Client #C1 was also in the van when Client #B1 and Client #B2 were picked up;
-Another unidentified client was in the van and "he was handicap ...somebody had to hold on to him ...[Client #C1] had to hold on to him ...[Client #C1] was holding him on his arms, so he won't hit nobody;"
-Client #C1 slept at the UL downstairs in the basement;
-Caretaker #1 had a client who hit "staff" and the client lives with Caretaker #1 all the time;
-Caretaker #1's client ran outside across the street and local law enforcement responded to the UL;
-Was brought to another house to sleep after local law enforcement left the UL;
-The UL had "dirty clothes on the floor, house was dirty with trash, smelled like poop, flies in the bedroom, and (Client #B1) could not sleep well because of the flies."

Interview on 12/4/2019 with Client #B2 revealed:
-Was a poor historian and was unable to identify any connection to the UL.

Interview on 12/4/2019 and 1/9/2020 with Client #C1 revealed:
-Went to the UL with Caretaker #1 every weekend since October, 2018;
-Initially denied sleeping at the UL or taking medications at the UL, but later acknowledged he did both;
-Was picked up by Caretaker #1 on Fridays and dropped off on Sunday nights before it got dark;
-Slept in the downstairs bedroom at times while at the UL;
-Would take medications at the UL because AFL Provider would label the medications;

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V 512	Continued From page 40 -Went to Caretaker #1's home and Caretaker #3 would also be present; -When Caretaker #1 drove and picked up other individuals, Client #C1 stayed with Caretaker #3 and an unknown male; -Went to flag football games with Caretaker #1 at times; -One day, after arriving back to the UL after flag football, local law enforcement was at the UL; -Caretaker #1 was not at the house when local law enforcement arrived on 10/26/2019 because he had to take Caretaker #2 to an appointment; -AFL Provider went to the UL to pick up Client #C1 from Caretaker #1 after local law enforcement arrived; -Had a good time at Caretaker #1's UL by watching movies and eating while the "AFLs relax and let them get situated with their families;" -Went away for the weekend to give the AFL Provider and his wife "a break;" -Was safe at the UL except for when some "bad clients" would "show off;" -Enjoyed spending time with Client #A1 at the UL; -Client B1 was "one of my best friends" and she stayed with us at the UL; -Never witnessed anyone locked in a bedroom at the UL; -One unidentified female client got mad because she could not take snacks, so she ran out of the UL because she did not like "no;" -The only problem at the UL was when individuals "don't get their own way" (Client #C1 could not elaborate on what this meant); -Did not go to the UL since local law enforcement involvement in October, 2019; -"It was nothing but fun at the [UL]." Interview on 1/14/2020 with investigating local law enforcement officer revealed: -Call report for the UL revealed:	V 512		

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V 512	Continued From page 41 -8/26/2019 call for 8-year-old children with possible IDD diagnoses playing in the garage; -9/1/2019 call for a female screaming and the local law enforcement being informed the residence housed individuals with IDD diagnoses; -Had seen Client #C1 and Client #A1 earlier in the day on 10/26/2019 at a fall festival at a new apartment complex in the city; -Conditions of the UL and the response of Caretaker #3 and Caretaker #4 to the local authorities on 10/26/2019 were disturbing and placed the individuals in the UL in life-threatening danger. Attempted interview on 12/6/2019 with CM #1 was unsuccessful. Voicemail messages were left for CM #1. No return telephone call was received. Interview on 12/6/2019 with CM #2 revealed: -Did not know who owned the home where the UL was operated, but believed it was a rental with option to buy. He had no information available on the individual who rented the home; -Had several concerns regarding the activities at UL. CM #2 revealed video surveillance from his cell phone dated 8/26/2019 at 12:16pm of an unknown Caucasian male with sandy brown hair who appeared to have been diagnosed with IDD wandering into his yard. There was nobody with the male and CM #2's voice could be heard on the video telling the individual to leave the premises; -Had expressed concern for the safety of his five-year-old son and identified that he no longer allowed his child to be alone in the family's backyard as he did not know who would wander into the yard from the UL; -A young female ran out of the UL during the last weekend in October, 2019 and ran to CM #1's	V 512		

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yard and hid behind a tree. The neighbor contacted local law enforcement. The young female reported having been assaulted and refused to go back to the UL. The young lady appeared fearful of the caretakers from the UL;
-Individuals with IDD come in and out of the UL on weekends and make a lot of noise. One individual "howls" on the back deck/patio while others wandered into his yard and knocked at the back door;
-Not uncommon to hear loud screaming or crying noises coming from the UL. Contacted local law enforcement approximately 6 months ago and there was no resolution. He again contacted local law enforcement during the last weekend in October, 2019.

Interview on 1/14/2020 with Caretaker #1 revealed:
-Started a Bed and Breakfast (B and B) for individuals with IDD at his private home;
-Received requests for the B and B through "word of mouth referrals;"
-Services provided at the UL did not have any affiliations with any licensee;
-Training on everyone served at the UL was given by the provider regarding backgrounds and diagnoses;
-Some individuals went to the UL from 1pm-9pm and other individuals spent the weekend;
-Caretaker #1 administered medications;
-IV bags hanging on the bedroom wall was for Caretaker #2 because she had Crohn's Disease and would dehydrate easily;
-Several Certified Nursing Assistants (CNAs) from Licensee A staffed the UL as a second job;
-Caretaker #5 did not work at the UL, but took several individuals to Special Olympics;
-Caretaker #5 took several individuals to a Fall Festival at an apartment complex on 10/26/2019

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but could not recall who went but did recall they were all males;
-Did not have or require a license for the services provided at the UL;
-Was paid cash to care for the individuals at the UL and, in turn, paid the caretakers cash;
-Provided transportation to and from the UL;
-Had a suspended North Carolina driver's license and did not have a valid driver's license from any other state.

Attempted interview on 1/14/2020 with Caretaker #2 was unsuccessful. A telephone message was left requesting a return call, but no call was ever returned.

Interview on 1/14/2020 with Caretaker #3 revealed:
-Worked for Caretaker #1 from January, 2019 through October, 2019;
-Lived at the UL with Caretaker #1 and Caretaker #2;
-Caretaker #3's 12-year-old daughter lived at the UL;
-No clients were present at the UL during the week, but only on the weekends;
-Caretaker #1 was not present at the UL when local law enforcement arrived on 10/26/2019;
-Caretaker #3 and Caretaker #4, along with 8 individuals with IDD, were present when local law enforcement arrived on 10/26/2019;
-Some individuals were on an outing with Caretaker #5 when local law enforcement arrived on 10/26/2019. They were "high functioning clients." Client #C1 was on the outing with Caretaker #5 and "can't remember" who else was on the outing;
-Was responsible for giving medications at the UL;
-Was a CNA;

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V 512	Continued From page 44 -Caretaker #1 would instruct Caretaker #3 on who would get what medications at what time; -Not sure how much Caretaker #1 would charge for each individual present at the UL but believed it was $50.00 cash; -Did not maintain a record of medications administered at the UL; -Did not have any records on the individuals served at the UL and was not sure if Caretaker #1 did either; -Caretaker #1 may have had records if there was a medical emergency or they would call 9-1-1; -After local law enforcement left the UL on 10/26/2019, Caretaker #1 took some individuals to an unknown location, but Caretaker #3 was not sure which individuals were left taken; -Was paid cash by Caretaker #1 for working at the UL. Interview on 1/14/2019 with Caretaker #4 revealed: -Worked part-time for Caretaker #1 at the UL; -Worked as an "assistant attendant" to watch individuals with IDD during the overnights; -Employed full-time by the local school district working with individuals with IDD; -Ensured individuals at the UL were fed and medicated; -Medication training at the UL was limited to being informed where the medications were stored; -Was unsure if there were any medical records maintained on the individuals at the UL but did recall "I saw one form;" -Had worked at the UL twice with different sets of individuals being there each Saturday; -Some individuals would always come but did not remember any individual's names because she "must be with a person five times or more before I would remember their names;" -Able to identify Client #1 by description and	V 512		

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revealed he "liked to be considered a help." Client #1 went out with Caretaker #5 and maybe 5 other individuals the day local law enforcement went to the UL;
-Could not identify the name of the individual who was in the room where the feces was smeared on the ceiling and walls but identified him as a minor child who attended the school where she worked. Believed she could identify the first name of the child but "it would be against HIPPA to know the child's last name, so I do not allow myself to learn the last names." The individual remained in the room asleep all day and she was not sure "if [he] was feeling sick."

Interview on 1/14/2020 with Caretaker #5 revealed:
-Knew Caretaker #1 through a work association at Licensee A for over 8 years;
-Offered to help Caretaker #1 with the UL;
-Picked up three individuals from the UL on 10/26/2019 at approximately 9:30am and returned them at approximately 3:30pm;
-Helped Caretaker #1 by doing volunteer work with the three individuals;
-Did not know the names of the individuals he picked up from the UL but did recall that there were 2 males and 1 female;
-Took the three individuals to Special Olympics and on an outing and brought them back to the UL;
-Did not have any paperwork on the three individuals and did not administer medications to the three individuals "but knew them by seeing them around [Licensee A facilities]";
-Arrived back to the UL when the local law enforcement was already present;
-Caretaker #1 was present at the UL when he arrived in the morning of 10/26/2019 but was not present when he returned in the afternoon of

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V 512	Continued From page 46 10/26/2019. Interview on 1/10/2020 with the owner of the home where the UL was operated revealed: -Rented the home to Caretaker #1 and Caretaker #2; -Caretaker #1 and Caretaker #2 have been renting the home for almost three years, with a current month-to-month rental agreement for the home; -Was contacted in October, 2019 by the local law enforcement agency and Fire Marshall regarding code violations; -Inspected the home in November, 2019 and made repairs to fire alarms; -Caretaker #1 denied any door was tied to a banister; -Was assured by Caretaker #1 and Caretaker #2 that no individuals with IDD were in the home. Interview on 1/21/2020 with the Regional Manager of Quality Management for the LME revealed: -Female #1 was from Licensee D and resided in a facility which did not require a DHSR mental health license; -Male #2 was from Licensee D and resided in a facility which did not require a DHSR mental health license; -Male #3 was from Licensee A receiving Community Living services at the time of the incident on 10/26/2019 and had since been placed in the home of Caretaker #1; -Male #4 was from Licensee C and resided in a facility which did not require a DHSR mental health license; -Upon discussion with DHSR surveyor, agreed to contact Licensee C to inform them of Male #4 being present at the UL during the weekend of 10/26/2019-10/27/2019;	V 512		

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V 512	Continued From page 47 -Had not made any other contacts to Licensee A or Licensee D regarding the local law enforcement report or the findings at the UL but ensured that DHSR was aware of the licensed facilities using the UL. Review on 1/24/2020 of a letter addressed to Division of Health Service Regulation (DHSR) from Licensee/CEO dated 1/24/2020 revealed: -" ...This letter serves as an official request to withdraw licensure for the following AFL facility [AFL Provider #1 and AFL Provider #2's facility] ...Still Family would like to close this licensed facility as of 2/24/20. Still Family has had some concerns regarding the AFL Provider (#1) and [AFL Provider #2] for this facility and can no longer have this facility under contract. The staff at this facility has been found to be negligent in the care of the members residing there. As you may be aware, AFL Providers are required to protect members from harm, abuse, neglect, and exploitation. They need to be reliable, dependable, and trustworthy as they work independently. Unfortunately, in order to safeguard Still Family members and the agency as a whole, we can no longer have this facility under contract ..." Review on 1/16/2020 of the 1st Plan of Protection (POP) written by the Director of QA/QI dated 1/16/2020 revealed: "What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? (V512) The members in the home will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. The Qualified Professional will research any suggested activity to ensure its compliance with state standards. The staff in the [AFL Facility] will	V 512		

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V 512	Continued From page 48 be retrained on the service definition of Residential, Abuse and Neglect, and the agency process on how to access respite services and utilize back-up services in the home. The [AFL Facility] will have increased supervision for up to one year, including unscheduled visits months (including Saturdays) by a Qualified Professional. [AFL Provider #1] and [AFL Provider #2] will receive disciplinary action (final written warning) with any further infractions terminating the license and separating from the agency. [The AFL Facility] will lose one member and the bed will not be filled for at least one year. (V367) Qualified Professionals will receive training on the following topics: 1. Ensuring staff complete incidents in the agency's medical record system (CCW - Client Care Web) within 24 hours of the incident; 2. When on-call, documenting that a directive was given to the reporting staff to complete the required incident in CCW on the on-call documentation form currently being submitted for calls; 3. Submitting the incident in lieu of the staff member when the staff member does not submit the incident timely; 4. Determining the level of response to incidents to aid in knowing what constitutes an incident that needs to be put into IRIS and CCW. Staff working in [AFL Facility} will be trained on submitting incident reports in CCW within 24 hours of the incident and notifying the assigned QP or the on-call QP of the incident and submission of the incident report. Consequences of not submitting incident reports timely (disciplinary action) will also included in this training. The QA/QI Director will ensure all level 2 and level 3 incidents are documented in IRIS within the 72 hour time frame and if there is an issue determining the level of response to an incident, the QA/QI Director will document in IRIS and seek clarity afterwards.	V 512		

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V 512	Continued From page 49 (V132, 318) The QA/QI Director will ensure that all level 3 investigations begin within 24 hours of notification of the incident. The QA/QI Director will create a tracker to track the progress of all level 3 internal investigations. Describe your plans to make sure the above happens. (V512) The QA/QI Director will ensure all trainings are completed by 1/20/20. The Qualified Professional will meet with the CEO and/or COO (Chief Operational Officer) to discuss supervision issues. The Qualified Professional will deliver disciplinary action to staff involved. (V367) The QA/QI Director will ensure all trainings are completed by 1/20/20. (132, 318) The CEO and/or COO will review the tracker created to ensure progress is being made with internal investigations." Review on 1/22/2020 of the 2nd Plan of Protection (POP) written by the Director of QA/QI revealed: "What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? (V1512) The members in the home will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. The Qualified Professional will research any suggested activity to ensure its compliance with state standards. The staff in the [AFL Facility] will be retrained on the service definition of Residential, Abuse and Neglect, and the agency process on how to access respite services and utilize back-up staff. The staff in the [AFL Facility] will ensure no unauthorized persons are caring for the members receiving services in the home. The [AFL Facility] will have increased supervision for up to one year, including	V 512		

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DEVIN STINNETT HOME	5401 HAMMERMILL DRIVE HARRISBURG, NC 28075

(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 512	Continued From page 50 unscheduled visits weekly (including weekends and holiday) by a Qualified Professional and/or QI/QA Director. During the weekly visits, the members will be interviewed. [AFL Provider #1] and [AFL Provider #2] will receive disciplinary action (final written warning) with any further infractions terminating the license and separating from the agency. The [AFL Facility] will lose one member and the bed will not be filled for at least one year. (V367) Qualified Professionals will receive training on the following topics: 1. ensuring staff complete incidents in the agency's medical record system (CCW-Client Care Web) within 24 hours of the incident; 2. When on-call, documenting that a directive was given to the reporting staff to complete the required incident in CCW on the on-call documentation form currently being submitted for calls; 3. Submitting the incident in lieu of the staff member when the staff member does not submit the incident timely; 4. Determining the level of response to incidents to aid in knowing what constitutes an incident that needs to be put into IRIS and CCW. Staff working in the [AFL Facility] will be trained on submitting incident reports in CCW within 24 hours of the incident and notifying the assigned QP or the on-call QP of the incident and submission of the incident report. Consequences of not submitting incident reports timely (disciplinary action) will also included in this training. The QI/QA Director will ensure all level 2 and level 3 incidents are documented in IRIS within the 72 hour time frame and if there is an issue determining the level of response to an incident, the QI/QA Director will document the incident in IRIS and seek clarity afterwards. (V132, 318) The QI/QA Director will ensure that all level 3 investigations begin within 24 hours of notification of the incident. The QI/QA Director will	V 512		

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V 512	Continued From page 51 create a tracker to track the progress of all level 3 internal investigations. Describe your plans to make sure the above happens. (V1512) The QI/QA Director will ensure all trainings are completed by 1/20/20. The Qualified Professional will meet with the CEO and/or COO to discuss supervision issues. The Qualified Professional will deliver disciplinary action to staff involved. (V367) The QI/QA Director will ensure all trainings are completed by 1/20/20. (V132, 318) The CEO and/or COO will review the tracker created to ensure progress is being made with internal investigations." Review on 1/23/2020 of the 3rd POP written by the Director of QA/QI revealed: "What will you do immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? (V1512) The members in the home will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. The Qualified Professional will research any suggested activity to ensure its compliance with state standards. The staff in the [AFL Facility] will be retrained on the service definition of Residential, Abuse and Neglect, and the agency process on how to access respite services and utilize back-up staff. The staff in the [AFL Facility] will ensure no unauthorized persons are caring for the members receiving services in the home. [AFL Facility] will have increased supervision for up to one year, including unscheduled visits weekly (including weekends and holidays) by a Qualified Professional and/or QI/QA Director. During the weekly visits, the members will be interviewed. [AFL Provider #1] and [AFL Provider #2] will receive disciplinary	V 512		

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V 512	Continued From page 52 action (final written warning) with any further infractions of any kind terminating employment with Still Family. The [AFL Facility] license will be terminated and member's moved. (V367) Qualified Professionals will receive training on the following topics: 1. ensuring staff complete incidents in the agency's medical record system (CCW-Client Care Web) within 24 hours of the incident; 2. When on-call, documenting that a directive was given to the reporting staff to complete the required incident in CCW on the on-call documentation form currently being submitted for calls; 3. Submitting the incident in lieu of the staff member when the staff member does not submit the incident timely; 4. Determining the level of response to incidents to aid in knowing what constitutes an incident that needs to be put into IRIS and CCW. Staff working in the [AFL Facility] will be trained on submitting incident reports in CCW within 24 hours of the incident and notifying the assigned QP or the on-call QP of the incident and submission of the incident report. Consequences of not submitting incident reports timely (disciplinary action) will also included in this training. The QI/QA Director will ensure all level 2 and level 3 incidents are documented in IRIS within the 72 hour time frame and if there is an issue determining the level of response to an incident, the QI/QA Director will document the incident in IRIS and seek clarity afterwards. (V132, 318) The QI/QA Director will ensure that all level 3 investigations begin within 24 hours of notification of the incident. The QI/QA Director will create a tracker to track the progress of all level 3 internal investigations. Describe your plans to make sure the above happens. (V1512) The QI/QA Director will ensure all trainings are completed by 1/20/20. The Qualified	V 512		

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V 512	Continued From page 53 Professional will meet with the CEO and/or COO to discuss supervision issues. The Qualified Professional will deliver disciplinary action to staff involved. (V367) The QI/QA Director will ensure all trainings are completed by 1/20/20. (V132, 318) The CEO and/or COO will review the tracker created to ensure progress is being made with internal investigations." Review on 1/24/2020 of the 4th POP written by the Director of QA/QI revealed: "What will you do immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? (V512) Still Family members will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. The Qualified Professional will research any suggested activity to ensure its compliance with state standards. An activity log will be implemented. This activity log will ensure the safety of members that live in both licensed and unlicensed homes contracted with Still Family. This document will be utilized to safeguard each member and to monitor the activities to ensure that all activities are approved and supported by the member's guardian and the Individual Support Plan. All AFL Providers and Qualified Professionals will be trained on this new procedure. All AFL Providers will be retrained on the service definition of Residential Supports and Respite Services. All AFL Providers will be retrained on the process access respite services and utilize back-up staff. All AFL Providers will be trained on the supervision requirements for each of the members in their home. Moreover, all AFL	V 512		

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V 512	Continued From page 54 Providers will be trained on ensuring no unauthorized persons are caring for or transporting the members receiving services. Only guardian approved natural supports and approved Still Family staff will be allowed to care for or transport members of Still Family. A policy will also be created addressing this issue. All AFL Providers will be trained on members being prohibited from spending any time in anyplace, albeit a home, business, or other without an approved Still Family staff member present and without ensuring that the home, business, or other does not compromise the health or safety of the member. This will be added to the above policy. All AFL Providers will be retrained on Abuse and Incident Reporting. All AFL Providers will be retrained on Core Values with emphasis on Integrity and Quality. In addition, all AFL Providers will receive Ethics training. The policy regarding Work Rules will be revised to include any substantiated allegation of abuse or neglect to be grounds for immediate termination. This will act as a deterrent from not adhering to the above new policy and any current policy in place to protect the health and safety of the members. The [AFL Facility] will have increased supervision for up to one year, including unscheduled visits weekly (including weekends and holidays) by a Qualified Professional and/or QI/QA Director. During the weekly visits, the members will be interviewed. The AFL Provider and back-up staff for the [AFL Facility] will receive disciplinary action (final written warning) with any further infractions of any kind terminating employment with Still Family. The agency will terminate the license for the [AFL Facility] and remove two members.	V 512		

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V 512	Continued From page 55 (V367) Qualified Professionals will receive training on the following topics: 1. ensuring staff complete incidents in the agency's medical record system (CCW-Client Care Web) within 24 hours of the incident; 2. When on-call, documenting that a directive was given to the reporting staff to complete the required incident in CCW on the on-call documentation form currently being submitted for calls; 3. Submitting the incident in lieu of the staff member when the staff member does not submit the incident timely; 4. Determining the level of response to incidents to aid in knowing what constitutes an incident that needs to be put into IRIS and CCW. Staff working in the [AFL Facility] will be trained on submitting incident reports in CCW within 24 hours of the incident and notifying the assigned QP or the on-call QP of the incident and submission of the incident report. Consequences of not submitting incident reports timely (disciplinary action) will also included in this training. The QI/QA Director will ensure all level 2 and level 3 incidents are documented in IRIS within the 72 hour time frame and if there is an issue determining the level of response to an incident, the QI/QA Director will document the incident in IRIS and seek clarity afterwards. (V132, 318) The QI/QA Director will ensure that all level 3 investigations begin within 24 hours of notification of the incident. The QI/QA Director will create a tracker to track the progress of all level 3 internal investigations. Describe your plans to make sure the above happens. (V1512) The QI/QA Director will ensure all trainings are completed by 1/31/20. The Qualified Professional will meet with the CEO and/or COO to discuss supervision issues. The Qualified Professional will deliver disciplinary action to staff involved.	V 512		

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V 512	Continued From page 56 (V367) The QI/QA Director will ensure all trainings are completed by 1/31/20. (V132, 318) The CEO and/or COO will review the tracker created to ensure progress is being made with internal investigations." With attachment of newly created activity log. Review on 1/24/2020 of the 5th POP written by the Director of QA/QI dated 1/24/2020 revealed: "What will you do immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? (V512) Still Family members will not engage in any activity unless the activity is approved by the guardian and the Qualified Professional. The Qualified Professional will research any suggested activity to ensure its compliance with state standards. An activity log will be implemented. This activity log will ensure the safety of members that live in both licensed and unlicensed homes contracted with Still Family. This document will be utilized to safeguard each member and to monitor the activities to ensure that all activities are approved and supported by the member's guardian and the Individual Support Plan. All AFL Providers and Qualified Professionals will be trained on this new procedure. All AFL Providers will be retrained on the service definition of Residential Supports and Respite Services. All AFL Providers will be retrained on the process access respite services and utilize back-up staff. All AFL Providers will be trained on the supervision requirements for each of the members in their home. Moreover, all AFL Providers will be trained on ensuring no unauthorized persons are caring for or transporting the members receiving services.	V 512		

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V 512	Continued From page 57 Only guardian approved natural supports and approved Still Family staff will be allowed to care for or transport members of Still Family. A policy will also be created addressing this issue. All AFL Providers will be trained on members being prohibited from spending any time in anyplace, albeit a home, business, or other without an approved Still Family staff member present and without ensuring that the home, business, or other does not compromise the health or safety of the member. This will be added to the above policy. All AFL Providers will be retrained on Abuse and Incident Reporting. All AFL Providers will be retrained on Core Values with emphasis on Integrity and Quality. In addition, all AFL Providers will receive Ethics training. The policy regarding Work Rules will be revised to include any substantiated allegation of abuse or neglect to be grounds for immediate termination. This will act as a deterrent from not adhering to the above new policy and any current policy in place to protect the health and safety of the members. The agency will terminate the license for the [AFL Facility] and remove all three members, and terminate the employment for the AFL Provider and the Back-up staff. (V367) Qualified Professionals will receive training on the following topics: 1. ensuring staff complete incidents in the agency's medical record system (CCW-Client Care Web) within 24 hours of the incident; 2. When on-call, documenting that a directive was given to the reporting staff to complete the required incident in CCW on the on-call documentation form currently being submitted for calls; 3. Submitting the incident in lieu of the staff member when the staff member	V 512		

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V 512	Continued From page 58 does not submit the incident timely; 4. Determining the level of response to incidents to aid in knowing what constitutes an incident that needs to be put into IRIS and CCW. Staff working in the [AFL Facility] will be trained on submitting incident reports in CCW within 24 hours of the incident and notifying the assigned QP or the on-call QP of the incident and submission of the incident report. Consequences of not submitting incident reports timely (disciplinary action) will also included in this training. The QI/QA Director will ensure all level 2 and level 3 incidents are documented in IRIS within the 72 hour time frame and if there is an issue determining the level of response to an incident, the QI/QA Director will document the incident in IRIS and seek clarity afterwards. (V132, 318) The QI/QA Director will ensure that all level 3 investigations begin within 24 hours of notification of the incident. The QI/QA Director will create a tracker to track the progress of all level 3 internal investigations. Describe your plans to make sure the above happens. (V1512) The QI/QA Director will ensure all trainings are completed by 1/31/20. The Qualified Professional will meet with the CEO and/or COO to discuss supervision issues. The Qualified Professional will deliver disciplinary action to staff involved. (V367) The QI/QA Director will ensure all trainings are completed by 1/31/20. (V132, 318) The CEO and/or COO will review the tracker created to ensure progress is being made with internal investigations." Client #1 is diagnosed with Autism, Epilepsy, IIDD Severe, Chronic Kidney Disease Stage 3,	V 512		

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V 512	Continued From page 59 Functional Disorder of the Bladder, Prune Belly Syndrome, Metabolic Acidosis, Obesity, Lipoma, Hypertension, History of Urinary Tract Infections, Neuromuscular Dysfunction of the Bladder, Benign Lipomatous Neoplasm, Acidosis, Calculus of the Kidney, Proteinuria, and Vitamin D Deficiency. Client #2 is diagnosed with IDD Moderate, Unspecified Psychosis, ADHD, Schizoaffective Disorder, and Impulse Disorder. The AFL Providers arranged for Client #1 and Client #2 to be transported by Caretaker #1 to an UL and remain there without proper supervision. Caretaker #1 provided transportation despite having a suspended driver's license. While at the UL, Client #1 and Client #2 were exposed to a plethora of health and safety concerns including, but not limited to, rooms without sheetrock and bare concrete floors, exposed electrical outlets, disarmed smoke and fire alarm systems, unsecured prescribed medications, illicit drugs, lack of emergency egress, and human waste on the floor, walls, and ceiling. Client #1 and Client #2 slept in a partially finished basement on worn furniture. The caretakers at the UL did not have any training to care for the needs of Client #1, Client #2 or the multiple other clients discovered at the location during the last weekend in October, 2019. Client #1 was prescribed multiple medications including, but not limited to, anti-psychotics, seizure control medications, and blood pressure medications. Client #2 was prescribed multiple medications including, but not limited to, mood stabilizers, cognition enhancing medications, thyroid control medications, and medications to improve skin integrity. It cannot be determined if Client #1 and Client #2 received their medications as ordered by the physician while at the UL. On 10/26/2019, local law enforcement discovered Client #2 at the UL at the same time he was scheduled for medication	V 512		

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V 512	Continued From page 60 administration. AFL Provider #1 and AFL Provider #2 denied Client #1 and Client #2 basic humane care and treatment when they chose to use the UL as a convenience so that the AFL providers could have free time on the weekends. It is unclear how long the use of the UL lasted. Furthermore, the QP, the Director of QA/QI, and the Licensee/CEO failed to protect Client #1 and Client #2 from neglect. Upon discovery of the use of the UL on 11/21/2019, the QP, Director of QA/QI, and Licensee/CEO failed to protect Client #1 and Client #2 by initiating an internal investigation, separating Client #1 and Client #2 from the alleged staff, and failing to report the incident to the LME. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		