Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601014	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER FAMILY HOME	1206 BERSHIRE LANE CHARLOTTE, NC 28262

(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 #NC00157787). A deficiency was 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	DHSR - Mental Health FEB 24 2020 Lic. & Cert. Section	
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 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	V 512	MHR will use our plan of Protection as our Plan of Correction (see attached)	ongoing

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Lynn E. Miller TITLE Executive Director (X6) DATE 2/20/2020

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V 512	Continued From page 1 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 Respite Staff (Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3) neglected 2 of 2 clients (Client #1 and Client #2). The findings are: Review on 12/2/2019 of Client #1's record revealed: -Admitted 10/1/2017; -Diagnosed with Autism, Unspecified Mood Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Phonological Disorder; -Physician's orders dated 4/29/2019 and October, 2019 Medication Administration Record (MAR) revealed Client #1's medications: -Thorazine (anti-psychotic) 150milligrams (mg) at bedtime as needed; -Propranolol (anger outbursts and behavioral control) 10mg twice daily at 7am and 10pm; -Bupropion (anti-depressant) 150mg 1 tab daily at 7am daily; -Treatment plan dated 10/1/2019 revealed respite services will be provided by the licensee. " ... [Client #1] require 1:1 services to meet his needs ...displays aggression towards others and has a history of throwing items at or near another individual, kicking, spitting, and/or hitting with an open palm ...verbal aggressive and will cursing and/or threatening others ...history of self-injurious behaviors and will biting his own	V 512	MCN will use our Plan of Protection as our plan of correction (re-attached)	ongoing

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V 512	Continued From page 2 arm and/or breaking objects and using them to cut his arm ...tantrum and will sitting down on the ground, crying and screaming loud enough to be heard from another room ...;" -Risk/Support Needs Assessment dated 7/23/2019 revealed " ...likes to use noise cancelling headphones if he is overstimulated ...support to participate in school, work and/or recreation within established rules ...because of difficulties with anger control, anxiety, depression or other intellectual disability ...requires a highly structed environment with specially trained staff ...requires close supervision due to the risk of wandering away ...requires support due to inability to make safe choices ...can be easily exploited by strangers ..." 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 11/15/2004; -Diagnosed with Hirschsprung's Disease (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; -Physician's orders dated 5/20/2018 and 2/26/2019 and October, 2019 MAR revealed Client #2's medications: -Ensure Plus (supplement) one can three times per day; -Multivitamin (supplement) 1 tab daily at 9am; -Pantoprazole (treats stomach related illnesses and high acid levels) 40mg 1 tab twice daily at 9am and 9pm; -Estradiol (birth control) 0.075mg 24 hour	V 512	MCN will use our Plan of Protection as our Plan of Correction (see attached)	Ongoing

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V 512	Continued From page 3 patched applied weekly; -Zonisamide (seizure control) 100mg 5 tabs daily at 9pm; -Cetirizine (allergy relief) 10mg 1 tab daily at 9pm; -Lamotrigine (seizure control) 25mg 4 tabs twice daily at 7am and 9pm; -Triamcinolone acetonide (treatment of skin conditions) 0.1% applied topically twice daily at 7am and 9pm; -Treatment plan dated 1/1/2019 did not reveal respite services were incorporated into Client #2's plan, but multiple staff from Unique Caring Network were identified as back-up staff. Has significant medical concerns requiring consistent supervision. Has a history of inappropriately touching unknown males at times. "It is best to avoid allowing strange males to come in close proximity of [Client #2]'s personal space ..." -Risk/Support Needs Assessment dated 8/15/2018 revealed Client #2 requires support to manage medical conditions, food to be cut into small nickel-sized pieces, has various guidelines for her diet, requires support due to risk of dehydration, and requires full assistance to communicate needs. " ...[Client #2] struggles with engagement and spends most of her day seeking out sensory stimulating activities. Those activities can often pose health and safety risks if she is not properly supervised. [Client #2] does not recognize danger or hazards in her home ..." she had a history of self-injurious behaviors and aggression. She 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 Attention Deficit Hyperactivity Disorder (ADHD), Mood Disorder, Intellectual	V 512	UCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 4 Developmental Disability (IDD) Mild, Oppositional Defiant Disorder (ODD), Impulse Control Disorder, Intermittent Explosive Disorder, Type 2 Diabetes, Asthma, Bilateral Myopia. 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 12/2/2019 of Client #C1's record revealed: -Diagnosed with Autism, Epilepsy, 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 #C2's record revealed: -Diagnosed with IDD Moderate, Unspecified Psychosis, ADHD, Schizoaffective Disorder, Impulse Disorder. 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)	V 512	VCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 5 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 8 individuals with special needs and 2 caretakers (Respite Staff/Caretaker #3 and Caretaker #4) in the residence ..." when local law enforcement entered the UL; -There were 11individuals 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 Unique Caring Network (Licensee); -1 client from Licensee A; -2 clients from Licensee B; -2 clients 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	V 512	VCN will use our Plan of Protection as the Plan of correction (see attached)	ongoing

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V 512	Continued From page 6 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 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 [Respite Staff/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	V 512	VCN will use our Plan of Protection as the Plan of Correction	ongoing

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V 512	Continued From page 7 we found a small amount of marijuana and pill bottles belonging to [Client #2] and [Respite Staff/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 [Respite Staff/Caretaker #3's child] (13 years-old). She said that she lives at this address with her mom. The room that [Respite Staff/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 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 [Respite Staff/Caretaker #3] for each of the occupants contact information and she said that she did not have it. She said that [Respite Staff/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. [Respite Staff/Caretaker #3] did not have any contact information for the subjects. The only thing she	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 8 had to know who they were, were their medical prescriptions. We asked [Respite Staff/Caretaker #3] to call [Respite Staff/Caretaker #1] and have him come back to the house. She said that she did and that it was going to take [Respite Staff/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 #1] ...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 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 #1] 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 [Respite Staff/Caretaker #3] to call [Respite Staff/Caretaker #1] to return back to the house. He arrived with [Caretaker #2] and a male individual (Male #3). [Respite Staff/Caretaker #1 and Caretaker #2] are renters (of the house). [Respite Staff/Caretaker #1] said that he has obtained the necessary certifications to act as a Mental Health Professional, or QP (Qualified Professional). [Respite Staff/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 [Respite Staff/Caretaker	V 512	We will use our Plan of Prodiction as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 9 #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. [Respite Staff/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 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 [Respite Staff/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 [Respite Staff/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	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 10 not charge the listed suspects. The suspect [Respite Staff/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 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 [Respite Staff/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 [Respite Staff/Caretaker #3] informed that she was a care giver and was a Certified Nursing Assistant (CNA) affiliated with [Licensee A] ...[Respite Staff/Caretaker #3] informed that she resides at these premises and cares for several special needs adults that are	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 11 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. [Respite Staff/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 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	V 512	VCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601014	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 12 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 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	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 13 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 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	V 512	VCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 14 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 Respite Staff/Caretaker #3; -Multiple household items cluttered countertops leaving no bare surface area; -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;	V 512	VCN will use our Plan B Protection as the Plan B Correction (see attached)	ongoing

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V 512	Continued From page 15 -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 department'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 with the AFL Provider's record revealed: -Hired 11/15/2004. Review on 12/2/2019 of the QP's record revealed: -Hired 12/3/2012. Review on 1/16/2020 of Respite Staff/Caretaker #1's record revealed: -Hired 3/12/2008; -Employed as a respite caretaker; -Job description signed and dated 1/16/2019 revealed duties included " ...assure consumers are free from abuse, mistreatment and or neglect ...provide a positive atmosphere which facilitates growth and learning ...make decisions based on training ...if providing transportation, have a North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance ...;" -Received client specific training for Client #1 on 9/20/2017;	V 512	VCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 16 -Medication Administration training completed 4/16/2019. Review on 1/13/2020 of Respite Staff/Caretaker #3's record revealed: -Hired 12/16/2018; -Employed as a respite caretaker; -Received training from a local institution as a CNA; -Received client specific training for Client #1 on 9/1/2019; -Received client specific training for Client #2 on 12/3/2018; -Medication Administration training completed 11/29/2018. Interview on 1/15/2020 with Client #1 revealed: -Spent time with Respite Staff/Caretaker #1 at the UL; -Respite Staff/Caretaker #1 picked him and Client #2 up from their AFL (Alternative Family Living) facility; -Went to a football game with Client #A1 with one of Respite Staff/Caretaker #1's helpers; -Local law enforcement was present at Respite Staff/Caretaker #1's UL when Client #1 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 "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	V 512	DCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 17 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 #2 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 #C1 and Client #C2 would attend the UL but would not go every weekend. They started by visiting and then spent nights; -Client #C1 and Client #C2 slept downstairs when they spent the whole weekend at the UL; -Client #1 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 #A1, who went to the UL every weekend. Interview on 1/13/2020 with Client #1's Legal Guardian revealed: -Was not aware of the presence of Client #1 at the UL but is pleased with Client #1's progress since moving into the AFL facility. Attempted interview on 1/15/2020 with Client #2 was unsuccessful as Client #2 was non-verbal. Interview on 1/16/2020 with the AFL Provider	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 18 revealed: -Was in need of respite services during the weekend of 10/26/2019 - 10/27/2019 and used trained respite caretakers employed by Unique Caring Network to provide services and supervision to Client #1 and Client #2. Interview on 1/15/2020 with the QP revealed: -Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3 were employees of Unique Caring Network; -AFL Provider used Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3 for respite services for Client #1 and Client #2 as they have been appropriately trained; -Had no information on the condition of Respite Staff/Caretaker #1's home or that he had multiple individuals diagnosed with IDD in the home requiring services; -Did not know Respite Staff/Caretaker #1 allowed Client #1 to go to an outing with Caretaker #5. Interview on 12/4/2019 and 1/9/2020 with Client #A1 revealed: -Went to the UL with Respite Staff/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 Respite Staff/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; -Went to Respite Staff/Caretaker #1's home and Respite Staff/Caretaker #3 would also be present;	V 512	UCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 19 -When Respite Staff/Caretaker #1 drove and picked up other individuals, Client #A1 stayed with Respite Staff/Caretaker #3 and an unknown male; -Went to flag football games with Respite Staff/Caretaker #1 at times; -One day, after arriving back to the UL after flag football, local law enforcement was at the UL; -Respite Staff/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 #1 from Respite Staff/Caretaker #1 after local law enforcement arrived; -Had a good time at Respite Staff/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 #1 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 #A1 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 12/4/2019 with Client #B1 revealed:	V 512	VCN will use our Plan of Protection as The Plan of Correction (see attached)	ongoing

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V 512	Continued From page 21 -Enjoyed spending time with Client #A1 while at the UL; -An unidentified female ran out of the UL and local law enforcement arrived; -Did not know the female's name; -Respite Staff/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; -Respite Staff/Caretaker #1 would give Client #C2 medication when Client #C2 was at the UL. Interview on 1/14/2020 with investigating local law enforcement officer revealed: -Call report for the UL revealed: -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 #1 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 Respite Staff/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:	V 512	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 20 -Was picked up by Respite Staff/Caretaker #1 to attend the "bed and breakfast" at the UL along with Client #B2; -Client #A1 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 #A1] had to hold on to him ...[Client #A1] was holding him on his arms, so he won't hit nobody;" -Client #A1 slept at the UL downstairs in the basement; -Respite Staff/Caretaker #1 had a client who hit "staff" and the client lives with Respite Staff/Caretaker #1 all the time; -Respite Staff/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 1/9/2020 with Client #C1 revealed: -Knew Respite Staff/Caretaker #1 but could not provide specifics on how. Interview on 1/9/2020 with Client #C2 revealed: -Respite Staff/Caretaker #1 picked him up at his AFL home; -Spent time with his friends while at the UL;	V 512	UCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 22 -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 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 Respite Staff/Caretaker #1 revealed:	V 512	VCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 23 -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 clients' AFL Provider regarding backgrounds and diagnoses; -Some individuals went to the UL from 1pm-9pm and other individuals spent the weekend; -Respite Staff/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 and 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 Respite Staff/Caretaker #3 revealed:	V 512	VCN will use our Plan of Protection as the Plan of Correction ongoing	

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	MHL0601014	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER FAMILY HOME	1206 BERSHIRE LANE CHARLOTTE, NC 28262

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V 512	Continued From page 24 -Worked for Respite Staff/Caretaker #1 from January, 2019 through October, 2019; -Lived at the UL with Respite Staff/Caretaker #1 and Caretaker #2; -Respite Staff/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; -Respite Staff/Caretaker #1 was not present at the UL when local law enforcement arrived on 10/26/2019; -Respite Staff/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 #1 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; -Respite Staff/Caretaker #1 would instruct Respite Staff/Caretaker #3 on who would get what medications at what time; -Not sure how much Respite Staff/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 Respite Staff/Caretaker #1 did either; -Respite Staff/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, Respite Staff/Caretaker #1 took	V 512	DCN will use our Plan of Protection as the Plan of correction (see attached)	ongoing

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V 512	Continued From page 25 some individuals to an unknown location but Respite Staff/Caretaker #3 was not sure which individuals were taken; -Was paid cash by Respite Staff/Caretaker #1 for working at the UL. Interview on 1/14/2019 with Caretaker #4 revealed: -Worked part-time for Respite Staff/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 #A1 by description and revealed he "liked to be considered a help." Client #A1 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	V 512	UCN will use the Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 26 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 Respite Staff/Caretaker #1 through a work association at Licensee A for over 8 years; -Offered to help Respite Staff/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 Respite Staff/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; -Respite Staff/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 10/26/2019. Interview on 1/10/2020 with the owner of the home where the UL was operated revealed: -Rented the home to Respite Staff/Caretaker #1 and Caretaker #2; -Respite Staff/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;	V 512	VCN will use our Plan of Protection as the Plan of Correction ongoing	

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V 512	Continued From page 27 -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; -Respite Staff/Caretaker #1 denied any door was tied to a banister; -Was assured by Respite Staff/Caretaker #1 and Caretaker #2 that no individuals with IDD were in the home. Interview on 1/16/2019 with the Licensee revealed: -Respite Staff/Caretaker #1, Respite Staff/Caretaker #3, and Caretaker #5 were employees of Unique Caring Network; -AFL Provider used Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3 for respite services for Client #1 and Client #2 as they have been appropriate trained; -Had no information on the condition of Respite Staff/Caretaker #1's home or that he had multiple individuals diagnosed with IDD in the home requiring services; -Did not know Respite Staff/Caretaker #1 allowed Client #1 to go to an outing with Caretaker #5; -Did not know Respite Staff/Caretaker #1 was providing transportation to clients without a valid driver's license; -Would ensure all clients receiving care from Unique Caring Network were served in locations free of any safety violations and would ensure only those properly trained would provide the services. 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	V 512	UCN will use Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 28 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 Unique Caring Network receiving Community Living services at the time of the incident on 10/26/2019 and had since been placed in the home of Respite Staff/Caretaker #1; -Male #4 was from Licensee A and resided in a facility which did not require a DHSR mental health license; -Upon discussion with DHSR surveyor, agreed to contact Licensee A to inform them of Male #4 being present at the UL during the weekend of 10/26/2019-10/27/2019; -Had not made any other contacts to Unique Caring Network 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. Three (3) Plans of Protection were submitted and reviewed by DHSR. Review on 1/16/2020 of the first Plan of Protection (POP) written by the QP dated 1/16/2020 revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -We will retrain the respite providers on health/safety, in the home and community to include transportation and medication; -QP will keep a tracking of the residential clients receiving respite dates times and locations when services are being provided; -QP will do a health and safety check of the respite homes;	V 512	VCN will use the Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 29 -QP will do unannounced visits to respite homes; -QP will train on the importance of reporting health and safety concerns along with incidents and accidents; -QP will implement the following plans to make sure this happens immediately; -QP will retrain respite providers on or before 1/31/2020; -QP will do unannounced visits to respite homes. Describe your plans to make sure the above happens. -QP will use residential health and safety tool to ensure that the home is in compliance with DHHS (Department of Health and Human Services); -QP will create a tracking log to track when respite is being provided to include the times, dates and locations; -QP will do unannounced visits to respite homes." Review on 1/23/2020 of the second POP written by the QP dated 1/22/2020 revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Describe your plan to make sure the above happens. How will UCN (Unique Caring Network) protect the clients? -When there is a concern/issue that comes up the QP/Stakeholders will provide an internal investigation. QP meet the individuals involved both provider and client(s). An incident report is completed and submitted within 48-72 hours. The QP will check in with individuals during next visit to ensure all safety standard continue to be met. What type of training will be provided?	V 512	UCN will use the Plan of Protection as the Plan of Correction (see attached)	ongoing

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V 512	Continued From page 30 -The respite provider will receive Health and Safety training to include: water temperature check, emergency contact numbers present, fire extinguisher checked, emergency crisis plan in place, check for privacy of medication and records -The respite providers will go through Core Training on topics: Client Rights and Confidentially, vehicle safety, Building Therapeutic Relationships, Person Centered Thinking, and Understanding service definition -The respite providers will receive Medication Training - keeping medications locked in secured location -Respite will receive EBPI training - Evidence Based Protective Intervention; knowing signs and triggers to enhance awareness for de-escalation -The respite provider will receive Client Specific Training -CPR (cardiopulmonary resuscitation)-First Aid Training is mandatory What will the direction of training be for respite providers? -Respite providers that are be providing services in their home will go through the 24 hour licensing facility Training to understand: Assessment & Treatment Planning, Client Rights & Confidentiality, CPR & First Aid, and population served, cultural awareness, Medications, and Restrictive Interventions. What happens when health and safety checks are not satisfactory? -The respite provider will be suspended from providing respite services -An Investigation will be completed -including incident report -The respite provider will receive a Corrective Action if necessary -The respite provider will go through a re-training	V 512	JCN will use our Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 31 if needed -Depending the outcome of the investigation the respite may or may not be allowed to provide respite services again Will there be changes to the treatment plan? -The QP will contact the Care Coordinator/MCO (Managed Care Organization) to update the list of providers that are currently working with the consumer to be reflected on the ISP (Individual Service Plan)." Review on 1/24/2020 of the third POP written by the QP dated 1/24/2020 revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -We will retrain the respite providers on health/safety, in the home and community to include transportation and medication; -QP will keep a tracking of the residential clients receiving respite dates times and locations when services are being provided; -QP will do a health and safety check of the respite homes; -QP will do unannounced visits to respite homes; -QP will train on the importance of reporting health and safety concerns along with incidents and accidents; -QP will implement the following plans to make sure this happens immediately; -QP will retrain respite providers on or before 1/31/2020; -QP will do unannounced visits to respite homes. Describe your plans to make sure the above happens. -QP will use residential health and safety tool to ensure that the home is in compliance with DHHS	V 512	NCN will use the Plan of Protection as our Plan of Correction (see attached)	ongoing

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V 512	Continued From page 32 (Department of Health and Human Services); -QP will create a tracking log to track when respite is being provided to include the times, dates and locations; -QP will do unannounced visits to respite homes." How will UCN (Unique Caring Network) protect the clients? -UCN will not send any consumer we serve to a respite home that is not pre-approved with our agency. -The respite homes approved by UCN are subject to the same monitoring/supervisions that our residential providers go through to ensure that the health and safety of the individuals are not compromised. -The respite provider assigned to provide the respite care cannot contract their assignment to another person. The respite provider will sign off an updated memo that they know and understand they are the ONLY person that can provide the respite services. -Prior to sending any consumer to a respite home, the QP will conduct a home visit to ensure health and safety of the consumer will not be compromised, as well as maintaining proper supervision for the consumer. -Corrective Action will be taken on any provider found violating the rules set of the agency and will no longer be allowed to provide respite services. What type of training will be provided? -The respite provider will receive Health and Safety training to include: water temperature check, emergency contact numbers present, fire extinguisher checked, emergency crisis plan in place, check for privacy of medication and records -The respite providers will go through Core Training on topics: Client Rights and	V 512	UCN will use our Plan of Protection as the Plan of Correction	ongoing

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V 512	Continued From page 33 Confidentially, vehicle safety, Building Therapeutic Relationships, Person Centered Thinking, and Understanding service definition -The respite providers will receive Medication Training - keeping medications locked in secured location -Respite will receive EBPI training - Evidence Based Protective Intervention; knowing signs and triggers to enhance awareness for de-escalation -The respite provider will receive Client Specific Training -CPR (Cardiopulmonary Resuscitation)-First Aid Training is mandatory What will the direction of training be for respite providers? -Respite providers that are be providing services in their home will go through the 24 hour licensing facility Training to understand: Assessment & Treatment Planning, Client Rights & Confidentiality, CPR & First Aid, and population served, cultural awareness, Medications, and Restrictive Interventions. What happens when health and safety checks are not satisfactory? -The respite provider will be suspended from providing respite services -An Investigation will be completed -including incident report -Respite provider will receive a Corrective Action if necessary -The respite provider will go through a re-training if needed -Depending the outcome of the investigation the respite may or may not be allowed to provide respite services again Will there be changes to the treatment plan? -The QP will contact the Care Coordinator/MCO (managed care organization) to update the list of	V 512	VCN will use the Plan of Protection as the Plan of Correction (see attached	ongoing

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V 512	Continued From page 34 providers that are currently working with the consumer to be reflected on the ISP Individual Service Plan)." Client #1was diagnosed with Autism, Unspecified Mood Disorder, ADHD, and Phonological Disorder. He requires 1:1 services and appropriately trained staff to support his needs. Client #2 was diagnosed with Hirschsprung's Disease, IDD Severe, Ileostomy, Epilepsy, Cerebral Palsy, Disease of the Urinary System, Enterocolitis, and Aphasia. She requires a high level of supervision as she engages in activities which pose health and safety risks if she is not properly supervised. Respite Staff/Caretaker #1 transported Client #1 and Client #2 despite having a suspended driver's license. Respite Staff/Caretaker #1 was Client #1's designated respite worker. Respite Staff/Caretaker #1 placed Client #1 in the care of Caretaker #5. Caretaker #5 could not identify Client #1 by name and had no specialized training regarding Client #1's needs. Caretaker #5 took Client #1 on community outings with several other individuals with IDD despite Client #1's treatment plan requirements of 1:1 supervision. Respite Staff/Caretaker #3 was Client #2's designated respite worker. Respite Staff/Caretaker #1 was engaged with the needs of several other clients with IDD, including leaving Client #1 alone while Respite Staff/Caretaker #3 responded to a client who had run away, on the weekend of 10/26/2019. Furthermore, 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	V 512	DCN will use the Plan of Protection as our Plan of Correction (see attached)	ongoing

Division of Health Service Regulation

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V 512	Continued From page 35 ceiling. Client #1 slept in a partially finished basement on worn furniture. Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3, along with three other caretakers, were left to care for the needs of multiple 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 and anti-depressants. Client #2 was prescribed multiple medications including, but not limited to, mood stabilizers, seizure control medication, birth control, allergy relief medications, medications to improve skin integrity, and supplements. It cannot be determined if Client #1 and Client #2 received their medications as ordered by the physician while at the UL. Respite Staff/Caretaker #1 and Respite Staff/Caretaker #3 denied Client #1 and Client #2 basic humane care and treatment. 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	VCN will use our Plan of Protection as the Plan of Correction (see attached)	ongoing

Unique Caring Network
Plan of Protection – follow up questions

1. How will UCN protect the clients?

- UCN will not send any consumer we serve to a respite home that is not pre-approved with our agency.
- The respite homes approved by UCN are subject to the same monitoring/supervisions that our residential providers go through to ensure that the health and safety of the individuals are not compromised.
- The respite provider assigned to provide the respite care cannot contract their assignment to another person. The respite provider will sign off an updated memo that they know and understand they are the ONLY person that can provide the respite services.
- Prior to sending any consumer to a respite home, the QP will conduct a home visit to ensure health and safety of the consumer will not be compromised, as well as maintaining proper supervision for the consumer.

Corrective Action will be taken on any provider found violating the rules set of the agency and will no longer be allowed to provide respite services.

2. What type of training will be provided?

- The respite provider will receive Health and Safety training to include: water temperature check, emergency contact numbers present, fire extinguisher checked, emergency crisis plan in place, check for privacy of medication and records
- The respite providers will go through Core Training on topics: Client Rights and Confidentially, vehicle safety, Building Therapeutic Relationships, Person Centered Thinking, and Understanding service definition
- The respite providers will receive Medication Training – keeping medications locked in secured location
- Respite will receive EBPI training – Evidence Based Protective Intervention; knowing signs and triggers to enhance awareness for de-escalation
- The respite provider will receive Client Specific Training
- CPR-First Aid Training is mandatory

3. What will the direction of training be for respite providers?

- Respite providers that are be providing services in their home will go through the 24 hour licensing facility Training to understand: Assessment & Treatment Planning, Client Rights & Confidentiality, CPR & First Aid, and population served, cultural awareness, Medications, and Restrictive Interventions.

4. What happens when health and safety checks are not satisfactory?

- The respite provider will be suspended from providing respite services
- An Investigation will be completed –including incident report
- The respite provider will receive a Corrective Action if necessary
- The respite provider will go through a re-training if needed

Unique Caring Network
Plan of Protection – follow up questions

Depending the outcome of the investigation the respite may or may not be allowed to provide respite services again

5. Will there be changes to the treatment plan?

- The QP will contact the Care Coordinator/MCO to update the list of providers that are currently working with the consumer to be reflected on the ISP.

Markeeta Fluker, QP