STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-116	A. BUILDING: _____ B. WING _____	C 09/19/2024

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SWEENY HOME	110 CAROLINA AVENUE MARION, NC 28752

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V 000	INITIAL COMMENTS A complaint survey was completed on 9/19/24. The complaint was substantiated (intake #NC00220898). Deficiencies were cited. This facility is licensed for the following service category: 10A NC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of an audit of 1 former client.	V 000	V 318 CEO will retrain Qualified Professionals on the 24 hour reporting requirements to the Health Care Registry. Training will include any and all types of allegations that must be reported along with the timeframe for reporting. Quality Assurance Director will monitor the completition of the 24 Hour reporting. QA will ensure that reporting has taken place the moment we receive an allegation. This monitoring will take place as reports are made.	11/1/2024
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). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of exploitation to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the	V 318	V 367 CEO will retrain Qualified Professionals on the 72 hour reporting requirements to the Iris System for level 2 and 3 reports. Training will include any and all types of level 2 and 3 incidents along with the time frame for completion. Quality Assurance Director will monitor the completition of IRIS reporting. QA will ensure that incident reports are completed within 72 hours. If someone fails to complete the report on time, they will be subject to a write up and possible termination. QA will monitor completion as incidents occur. RECEIVED OCT 21 2024 DHSR-MH Licensure Sect	11/1/2024

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V 318	Continued From page 1 allegation. The findings are: Review on 9/17/24 of Former Client (FC) #1's record revealed: -Date of Admission: 6/27/24. -Date of Discharge: 6/30/24. -Diagnoses: Schizoaffective Disorder, Bipolar Type; Intellectual Disability; Autism Spectrum Disorder; Posttraumatic Stress Disorder; Major Depressive Disorder, Recurrent Episode, Moderate. Review on 9/17/24 of the internal investigation report completed by the Chief Executive Officer (CEO) dated 8/16/24 revealed: -"Received a call from [Local Management Entity/Management Care Organization Care Coordinator], they received a grievance that [Former AFL Provider (FAFLP)] was using a pervious member's (FC #1) bank card while he was in the hospital (6/29/24-6/30/24)." -"Has 24-Hour Report to Health Care Registry Been Completed: Yes." Review on 9/19/24 of an email from the HCPR Consultant revealed: -The date of the allegation involving FC #1 was made on 8/15/2024. -The allegation was initially reported to HCPR on 8/19/2024. Interview on 9/17/24 with the Qualified Professional (QP) revealed: -He was the "only one" responsible for reporting any allegations of abuse, neglect and exploitation for FC #1. -He was "not aware" that allegations of exploitation were required to be reported to HCPR within 24 hours of being notified of the allegation, "...the exploitation piece...I know now."	V 318	V 500 CEO will retrain Qualified Professionals on the reporting requirements to DSS. Training will include any and all types of allegations that must be reported along with the timeframe for reporting. Documentation of the call to DSS will be documented with contact name, date, and time of report. Quality Assurance Director will monitor the completition of the DSS reporting. QA will ensure that reporting has taken place the moment we receive an allegation. This monitoring will take place as reports are made.	11/1/2024

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V 318	Continued From page 2 -The CEO provided oversight to him with reporting allegations of abuse, neglect or exploitation to HCPR. Interview on 9/19/24 with the Quality Assurance Director revealed: -The "CEO or QP" was responsible for reporting any allegations to HCPR within 24 hours of becoming aware of the allegation. Attempted interview on 9/19/24 with the CEO was unsuccessful as the CEO was on vacation and unavailabe for interview.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR 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;	V 367		

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V 367	Continued From page 3 (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: (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	V 367		

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V 367	Continued From page 4 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level III incidents in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review on 9/17/24 of Former Client (FC) #1's record revealed: -Date of Admission: 6/27/24. -Date of Discharge: 6/30/24. -Diagnoses: Schizoaffective Disorder, Bipolar Type; Intellectual Disability; Autism Spectrum Disorder; Posttraumatic Stress Disorder; Major Depressive Disorder, Recurrent Episode,	V 367		

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V 367	Continued From page 5 Moderate. Review on 9/17/24 of the IRIS report for FC #1 submitted 8/19/24 revealed: -The Chief Executive Officer (CEO) was notified of an allegation of exploitation involving FC #1 on 8/15/24. Interview on 9/19/24 with the IRIS Consultant revealed: -An IRIS report for the allegation of exploitation involving Client #1 on 8/15/24 was submitted on 8/19/24. Interview on 9/17/24 with the Qualified Professional revealed: -He was responsible for completing the IRIS report for FC #1. -He "was aware" of the reporting requirements for level III incidents to be reported to IRIS within 72 hours of becoming aware of the incident. -The IRIS report for the 8/15/24 incident was not completed within 72 hours of becoming aware of the incident because of "my shortcomings...not sure why it was done outside of that 72-hour window." Interview on 9/19/24 with the Quality Assurance Director revealed: -Was responsible for putting the facility information into the IRIS report, "...I put the basic info (information) in." -The IRIS report was not completed within the 72-hour time frame of becoming aware of the incident because "...[CEO] was trying to investigate the allegation...think it was us trying to fact check the situation before submitting...that is why it was late." Attempted interview on 9/19/24 with the CEO was	V 367		

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V 367	Continued From page 6 unsuccessful as the CEO was on vacation and unavailable for interview.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions;	V 500		

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V 500	Continued From page 7 (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged exploitation were reported to the Local Department of Social Services (DSS) affecting 1 of 1 Former Client (FC #1). The findings are: Review on 9/17/24 of FC #1's record revealed: -Date of Admission: 6/27/24. -Date of Discharge: 6/30/24. -Diagnoses: Schizoaffective Disorder, Bipolar Type; Intellectual Disability; Autism Spectrum	V 500		

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V 500	Continued From page 8 Disorder; Posttraumatic Stress Disorder; Major Depressive Disorder, Recurrent Episode, Moderate. Review on 9/17/24 of the Incident Response Improvement System (IRIS) report for FC #1 submitted 8/19/24 revealed: -The Chief Execuitve Officer (CEO) was notified of an allegation of exploitation which involved FC #1 on 8/15/24. -No documentation of the allegation of exploitation being reported to DSS. Review on 9/17/24 of the internal investigation report completed by the CEO dated 8/16/24 revealed: -"Has DSS been contacted: No." Interview on 9/17/24 with the Qualified Professional revealed: -"Only one" responsible for reporting any allegations of abuse, neglect and exploitation for FC #1. -"Not aware" that allegations of exploitation were required to be reported to DSS, "...the exploitation piece...I know now." Interviews on 9/17/24 and 9/19/24 with the Quality Assurance Director revealed: -She did not notify DSS, "...I didn't call nobody." -"[CEO] didn't talk to DSS (about the allegation of exploitation involving FC #1)." -When the CEO talked with the Former Alternative Family Living Provider "all the money was accounted for" and "didn't feel like" she needed to contact DSS. Attempted interview on 9/19/24 with the CEO was unsuccessful as the CEO was on vacation and unavailable for interview.	V 500		

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