STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-177	A. BUILDING: _____ B. WING _____	03/31/2022

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JOHNSTON RECOVERY SERVICES	1699 OLD US HIGHWAY 70 WEST CLAYTON, NC 27520

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V 000	INITIAL COMMENTS An annual survey was completed on March 31, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. This facility has a current census of 339. The survey sample consisted of audits of 17 current clients and 2 former clients.	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 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	V 132		

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V 132	Continued From page 1 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 record reviews and interviews, the facility failed to ensure allegations of abuse were reported to the North Carolina Health Care Personnel Registry (HCPR) of the Division of Health Service Regulation within five working days affecting one of seventeen audited current clients (client #1). The findings are: Review on 3/31/22 of client #1's record revealed: -Admission date of 8/19/20. -Diagnoses of Severe Opioid Use Disorder, Post-Traumatic Stress Disorder and Severe Cannabis Use Disorder. Review on 3/31/22 of the facility's personnel files revealed: -Former Staff #6 (FC #6) had a hire date of	V 132		

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V 132	Continued From page 2 1/26/16. -FS #6 was hired as a Security Guard. -FS #6 last day of employment was 1/6/22. Review of facility records on 3/31/22 revealed: -Case Note dated 12/6/21 written by the Program Director had the following: On 12/6/21 "Client #1 had an explosive episode alleging that [FS #6] had called him a f****t which made him angry thus causing his outburst. This Writer explained that his complaint would be investigated , but again he would not be permitted to curse and swear at any staff member of Johnston Recovery Services." -There was no documentation the facility reported the above allegation of abuse to North Carolina HCPR. Interview on 3/31/22 with client #1 revealed: -He had been receiving services at the clinic for over a year. -He had an incident with a male staff back in December 2021. He could not remember the name of the male staff. -He had an injury to his ankle and was not able to walk. He requested to have a car dose. -The male staff called him a "f****t" and said he had two options. The male staff said he could use the wheelchair to come in or wait until the nurse came to the car. -He did file a grievance with the clinic about that incident. -He had not seen the male staff working at the clinic since that incident. Interview on 3/31/22 with the Program Director revealed: -Client #1 filed a grievance with the clinic. -There was an incident that occurred around December 7, 2021 with client #1. Client #1	V 132		

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V 132	Continued From page 3 alleged FS #6 called him a "f****t." -He tried to talk to client #1 shortly after the incident. Client #1 rolled up the window and would not talk to him. -They were doing car dosing for special circumstances. Client #1 had been doing car dosing due to his leg being fractured. -He thought client #1 was upset due to the wait time and because he was asked to get a doctor's order to continue car dosing. -When he talked to FS #6 he denied calling client #1 a "f****t." -He didn't do an investigation about the incident between client #1 and FS #6. -He did not realize he was supposed to report this incident to HCPR as an allegation of abuse. -His main concern was trying to persuade client #1 to get a doctors order to continue car dosing. -He confirmed the agency had not reported the alleged incident of abuse to North Carolina HCPR within five working days.	V 132		
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,	V 367		

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V 367	Continued From page 4 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: (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	V 367		

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V 367	Continued From page 5 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:	V 367		

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V 367	Continued From page 6 Review on 3/31/22 of client #1's record revealed: -Admission date of 8/19/20. -Diagnoses of Severe Opioid Use Disorder, Post-Traumatic Stress Disorder and Severe Cannabis Use Disorder. Review on 3/31/22 of the facility's personnel files revealed: -Former Staff #6 (FC #6) had a hire date of 1/26/16. -FS #6 was hired as a Security Guard. -FS #6 last day of employment was 1/6/22. Review of facility records on 3/31/22 revealed: -Case Note dated 12/6/21 written by the Program Director had the following: On 12/6/21 "Client #1 had an explosive episode alleging that [FS #6] had called him a f****t which made him angry thus causing his outburst. This Writer explained that his complaint would be investigated , but again he would not be permitted to curse and swear at any staff member of Johnston Recovery Services." -There was no documentation a incident report in the Incident Response Improvement System (IRIS) for the above incident. Interview on 3/31/22 with client #1 revealed: -He had been receiving services at the clinic for over a year. -He had an incident with a male staff back in December 2021. He could not remember the name of the male staff. -He had an injury to his ankle and was not able to walk. He requested to have a car dose. -The male staff called him a "f****t" and said he had two options. The male staff said he could use the wheelchair to come in or wait until the nurse came to the car. -He did file a grievance with the clinic about that	V 367		

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V 367	Continued From page 7 incident. -He had not seen the male staff working at the clinic since that incident. Interview on 3/31/22 with the Program Director revealed: -Client #1 filed a grievance with the clinic. -There was an incident that occurred around December 7, 2021 with client #1. Client #1 alleged FS #6 called him a "f****t." -He tried to talk to client #1 shortly after the incident. Client #1 rolled up the window and would not talk to him. -They were doing car dosing for special circumstances. Client #1 had been doing car dosing due to his leg being fractured. -He thought client #1 was upset due to the wait time and because he was asked to get a doctor's order to continue car dosing. -When he talked to FS #6 he denied calling client #1 a "f****t." -He didn't do an investigation about the incident between client #1 and FS #6. -He did not realize he was supposed to put this incident into the Incident Response Improvement System (IRIS). -His main concern was trying to persuade client #1 to get a doctors order to continue car dosing. -He confirmed the facility failed to ensure a Level III incident report was submitted to the Local Management Entity (LME) within 72 hours as required.	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,	V 500		

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V 500	Continued From page 8 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; (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,	V 500		

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V 500	Continued From page 9 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 governing body failed to report an allegation of abuse to Department of Social Services (DSS) affecting one of seventeen audited current clients (#1). The findings are: Review on 3/31/22 of client #1's record revealed: -Admission date of 8/19/20. -Diagnoses of Severe Opioid Use Disorder, Post-Traumatic Stress Disorder and Severe Cannabis Use Disorder. Review on 3/31/22 of the facility's personnel files revealed: -Former Staff #6 (FC #6) had a hire date of 1/26/16. -FS #6 was hired as a Security Guard. -FS #6 last day of employment was 1/6/22. Review of facility records on 3/31/22 revealed:	V 500		

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V 500	Continued From page 10	V 500		

-Case Note dated 12/6/21 written by the Program Director had the following: On 12/6/21 "Client #1 had an explosive episode alleging that [FS #6] had called him a f****t which made him angry thus causing his outburst. This Writer explained that his complaint would be investigated , but again he would not be permitted to curse and swear at any staff member of Johnston Recovery Services."
-There was no documentation that the facility reported the above allegation of abuse to DSS.

Interview on 3/31/22 with client #1 revealed:
-He had been receiving services at the clinic for over a year.
-He had an incident with a male staff back in December 2021. He could not remember the name of the male staff.
-He had an injury to his ankle and was not able to walk. He requested to have a car dose.
-The male staff called him a "f****t" and said he had two options. The male staff said he could use the wheelchair to come in or wait until the nurse came to the car.
-He did file a grievance with the clinic about that incident.
-He had not seen the male staff working at the clinic since that incident.

Interview on 3/31/22 with the Program Director revealed:
-Client #1 filed a grievance with the clinic.
-There was an incident that occurred around December 7, 2021 with client #1. Client #1 alleged FS #6 called him a "f****t."
-He tried to talk to client #1 shortly after the incident. Client #1 rolled up the window and would not talk to him.
-They were doing car dosing for special circumstances. Client #1 had been doing car

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V 500	Continued From page 11 dosing due to his leg being fractured. -He thought client #1 was upset due to the wait time and because he was asked to get a doctor's order to continue car dosing. -When he talked to FS #6 he denied calling client #1 a "f****t." -He didn't do an investigation about the incident between client #1 and FS #6. -He did not realize he was supposed to report this incident to DSS as alleged abuse. -His main concern was trying to persuade client #1 to get a doctors order to continue car dosing. -He confirmed the agency failed to report the allegation of abuse to DSS.	V 500		