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
	MHL001-169	A. BUILDING: _____ B. WING _____	12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES II	111 DOGWOOD DRIVE BURLINGTON, NC 27215

(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 and annual survey was completed on 12/14/18. Deficiencies were cited. The complaint was unsubstantiated. (Complait ID #NC00145249.) This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children and Adolescents.	V 000	RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 2:35 pm, Jan 10, 2019	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Staff will ensure all assessments are completed within 30 day of the admission date, whether It be face to face video chat or over the phone. The house manager/ QP/ Director will monitor staff to make sure all assessments are being completed. JITYS will makes sure that staff is knowledgeable in every aspect of each clients person's centered.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE House Manager

(X6) DATE 1/2/2019

STATE FORM 6899 VWJC11 If continuation sheet 1 of 13

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement strategies in the treatment plan for 1 of 1 former client's (FC #1.) The findings are:

Review on 11/30/18 of FC #1's record revealed:
- Admission date of 8/7/18
- Discharge date of 11/21/18
- Diagnoses of Attention Deficit Hyperactivity Disorder - Combined; Conduct Disorder - Childhood On-set.

Further review on 11/30/18 of FC #1's record revealed a treatment plan dated 7/10/18 documenting the following:
- "needs the Level II group setting to assist in the development of therapeutic skills that will allow him to manage his behavior in a healthy manner." - "residential staff to assist him in being able to de-escalate in a therapeutic manner and assist him in the providing of feedback regarding his behavior."
- Strategies recommended to address the client's need included the following:
1) dialectical behavior therapy to include a skill-building group to meet the client's need to develop coping skills
2) a trauma evaluation with specific measurements and trauma-focused treatment "to focus on grief and loss due to loss of father." 3) substance abuse evaluation and treatment 4) prioritization of family treatment and therapeutic leave for reunification
(recommendation by Department of Social Services in client's county)
5) continuously advocate for the above identified

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V 112	Continued From page 2 services "to insure his well-being needs are addressed appropriately." Additional review on 11/30/18 of the client's treatment plan revealed "How Best To Support" the client and strategies to implement to prevent a crisis included: 1) "give him space when he is upset;" stop talking to him. 2) "Do not engage in a battle with him;" "Do not go back and forth with him in an argument...does not know when to let things go." 3) Per client: "Don't argue with me and leave me alone." "I need to have time to myself." Review on 12/4/18 of Staff #1's documentation of an incident dated 10/4/18 for FC #1 revealed: - Client missed the school bus and had to be picked up by the staff responsible for transportation. - Client became angry and began making verbal threats during the ride home when the transportation staff began discussing consequences the client would receive. - Client entered the facility, "kicked the front door, stormed in cursing and belligerent." - FC #1 went to his room and Staff #1 followed the client in an attempt to "process with" him - The client became more upset when staff tried to talk to him. He continued to use profanity" then "threw his amp and attempted to throw his guitar." - Staff continued to try and "process" with client in an attempt to get him to "calm down." - FC #1 became more upset and punched the wall in his room. Additional review on 12/4/18 of documentation related to FC #1 revealed the following incident report: - One incident related to the above 10/4/18	V 112		

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V 112	Continued From page 3 incident for FC #1 which resulted in a physical restraint. - No documentation FC #1 was previously restrained. - The following documentation by the Residential Director of the 10/4/18 incident: 1. "Director intervened when client was displaying aggressive behaviors verbally (cursing, yelling, and screaming) and physically (punching walls, kicking doors, and throwing things.)" 2. The Residential Director "directed" FC #1 to "settle down and get himself under control." 3. FC #1 became more verbally aggressive and "attempted to throw his guitar." 4. The Residential Director then physically restrained the client. Further review on 12/4/18 of a Child Family Team Meeting (CFT) for FC #1's revealed: - CFT meeting occurred prior to the client leaving school and on the same day as above incident. - Documentation dated 10/4/18 of a positive report on his school behavior. - [FC #1] is responding well to proactive strategies put in place" - Client was reported to have good communication with staff regarding his needs" and "will ask to see an administrator or other support when needed instead of walking out." - Client was reported to be a "good self-advocate." During interview on 12/4/18, staff responsible for transportation reported: - He works as "as-needed" staff and school transport/pick-up for clients in the facility. - He questioned FC #1 about missing the bus then asked the client for his daily academic sheet and the client "was unable to produce one." - During the transport home, the staff told FC #1,	V 112		

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V 112	Continued From page 4 he would have "consequences" as a result of not having his academic sheet. - He informed FC #1 the final decision about consequences (including possible restriction from home visit) would be determined by Residential Director and/or Licensee/Qualified Professional (QP.) - FC #1 then made verbal threats against the Residential Director and the staff said he told the client he would have to report the threats to the Residential Director. - He thought FC #1 was calm when he left the vehicle. - He did not go into the facility however, he noticed the Residential Director's vehicle and determined he was present in the facility when he dropped the client off. During interview on 11/28/18, Staff #1 said: - After being dropped off from school, FC #1 slammed the door when he entered the facility. He was cursing and pacing. - FC #1 cursed in response to her questions to determine why he was upset. - Another client in the facility told FC #1 not to curse the staff and FC #1 went to his room. She said "He (FC #1) walked past me but avoided hitting me. I knew he didn't want to attack me." - She heard him punch the wall and followed FC #1 to his room. "I didn't follow him too closely." - She tried to talk to the client to determine what was wrong. She wanted to "monitor" him. "I didn't want him to hurt himself." - "He didn't seem agitated but he used profanity. I wanted to see if he was alright. I wanted to see how far he would go." - He was trying to break his own property because he felt he would not "get a charge." - The Residential Director is the final decision-maker regarding consequences	V 112		

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V 112	Continued From page 5 implemented for problem behaviors. FC #1 said the Residential Director was going to take"all his privileges" away. - "He (FC #1) already knew if he missed the bus he was going to get his home visit taken." FC #1 told her he was going to hit the Residential Director when he saw him. - She left the client's room and went downstairs where the other clients were located. "They were worried. It was the first time we experienced that (with FC #1.) I knew, based on reading his chart about how angry he could get." - She did not receive specific training in how to manage behaviors like FC #1 displayed when he was in a crisis nor was she trained in a facility behavior management program. - She managed client behaviors based on her own experiences and observations of how other staff managed the clients. - She contacted the Residential Director when the client continued to swing his guitar around in an attempt to break it. Interview on 12/4/18 with FC #1's guardian reported: - The Licensee/QP told her FC #1 was restrained and received the consequence because he failed to follow staff directions. FC #1 had an incident at school and the Licensee/QP added that to the consequence for more punishment. - FC #1's home visits were restricted because of his behavior. She said "[Licensee/QP] didn't want him down here (at her home.)" - FC #1 said he was angry with the Residential Director because his home visits were taken. - She reported the client sustained a bruise on his arm after the restraint. - FC #1 was afraid after the Residential Director restrained him. He said the Residential Director told him he did not listen to orders and did not	V 112		

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V 112	Continued From page 6 abide by the rules. - Staff did not follow the client's treatment plan and did not treat FC #1 fairly. - She requested an earlier court date so she could take FC #1 out of the facility. Above interviews with staff confirmed the crisis prevention strategies in FC #1's treatment plan were not implemented.	V 112		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search;(4) a description of any property seized; and (5) an account of the disposition of seized property. This Rule is not met as evidenced by: based on record reviews and interviews, the facility failed to: a) implement policy that specified the conditions under which the seizure of belongings and/or property in the possession of 1	V 503		

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V 503	Continued From page 7 of 1 of former client (FC #1) and b) failed to document the seizure of the property. Review on 11/30/18 of FC #1's record revealed: - Admission date of 8/7/18 - Discharge date of 11/21/18 - Diagnoses of Attention Deficit Hyperactivity Disorder - Combined; Conduct Disorder - Childhood On-set. Review on 11/30/18 of the facility's incident reports revealed the following examples when a client's belongings were seized by staff: 1. 8/10/18 - Staff had placed FC #1 on a "restriction" (unidentified) as a result of the client being in another client's room without staff permission. He was later found again in the same client's room. As a consequence, staff took the client's bass guitar and recommended no home visit. 2. 9/5/18 - FC #1 requested to use the bathroom upstairs. Staff went upstairs when he thought an incident was occurring between two clients. Staff witnessed the other client "handing [FC #1] something and [FC #1] put it in his pocket." Staff twice directed FC #1 to surrender the contents of his pocket. FC #1 refused and staff "then removed the object from [FC #1.]" During interview on 12/4/18, FC #1's guardian/Aunt revealed: - She gave the client a cell phone so he could contact her. - Before he was discharged to her home, the Licensee took his cell phone and "never let him have it back." - Staff did not inform her the phone had been taken from FC #1 nor explain why. - She demanded the phone be returned, then took it to her home.	V 503	Group home will provide documentation for search and seizer and will make staff more knowledgeable on the search and seizure as well as policy procedure. QP/ Director will provide in house training monthly. After 90 day is staff is still unsure of their responsibilities they will be terminated.	

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V 503	Continued From page 8 Additional review on 11/30/18 of the facility's policies and procedures revealed: - The facility has a form for staff to document all required information when they conduct a search and/or seizure of a client's belongings and/or property. - However, no documentation was found of the above seizures. During interview on 12/4/18, the Program Director said: - Search and/or seizures of clients and/or their property were only completed if there was a suspicion of contraband. - Staff had not conducted any client search or seizures in the past year. - Seizure of client property was documented in Level I incident reports. - He confirmed the above identified searches and/or seizures were not documented on the facility's form and completed with the required information.	V 503		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and	V 513	Staff will read and understand the person's centered plan and crisis intervention plan to ensure they're providing the client with the right treatment and assisting them with using the proper coping skill. Staff will continue to receive in house training with QP/ program director as well as monthly training where we will discuss progress on clients and staff. Incident reports will be checked daily to ensure a consistent behavioral pattern is being present. Staff will make sure clients are receiving the proper therapy to assist with using the proper coping skill as well as unidentified trauma.	

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V 513	Continued From page 9 (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to use physical restraint as a last resort and follow the restrictive intervention with actions to insure the client's physical well-being affecting 1 of 1 former clients (FC #1.) The findings are: Review on 11/30/18 of FC #1's record revealed: - Admission date of 8/7/18 - Discharge date of 11/21/18 - Diagnoses of Attention Deficit Hyperactivity Disorder - Combined; Conduct Disorder - Childhood On-set. Review on 12/4/18 of the facility's incident reports revealed: - One incident related to FC #1 on 10/4/18 which resulted in a physical restraint. - No documentation FC #1 was previously restrained. - The following documentation by the Residential Director of the 10/4/18 incident: 1. "Director intervened when client was displaying aggressive behaviors verbally (cursing, yelling,	V 513		

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V 513	Continued From page 10 and screaming) and physically (punching walls, kicking doors, and throwing things.)" 2. The Residential Director "directed" FC #1 to "settle down and get himself under control." 3. FC #1 became more verbally aggressive and "attempted to throw his guitar." 4. The Residential Director then physically restrained the client. Review on 12/4/18 of Staff #1's documentation of the incident dated 10/4/18 for FC #1 revealed: - Client missed the school bus and had to be picked up by the staff responsible for transportation. - Client became angry and began making verbal threats during the ride home when the transportation staff began discussing consequences the client would receive. - Client entered the facility, "kicked the front door, stormed in cursing and belligerent." - FC #1 went to his room and Staff #1 followed the client in an attempt to "process with" him - The client became more upset when staff tried to talk to him. He continued to use profanity" then "threw his amp and attempted to throw his guitar." - Staff continued to try and "process" with client in an attempt to get him to "calm down." During interview on 11/28/18, Staff #1 said: - FC #1 cursed in response to her questions to determine why he was upset. - Another client in the facility told FC #1 not to curse the staff and FC #1 went to his room. She said "He (FC #1) walked past me but avoided hitting me." - She "knew" the client didn't want to attack her and did not think the client seemed "agitated" although he was using profanity.	V 513		

	- FC #1 was damaging his own property so he would not "get a charge." The client engages in			

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V 513	Continued From page 11	V 513		
	this behavior when upset. Review on 12/4/18 of the incident report regarding the restraint on FC #1 on 10/4/18 revealed the Residential Director documented: - FC #1 "attempted to throw his guitar." At that point he restrained the client. He "felt it to be necessary to utilize NCI approved method of Therapeutic Wrap." - He released the client after he "acknowledged he would comply with directives without any further disruptions." - He "monitored" the client for approximately 5 minutes after he released the client. However, he did not physically check the client for injuries nor did he ask FC #1 if he felt any discomfort. Interview on 12/4/18 with FC #1's guardian reported: - The Licensee/QP told her FC #1 was restrained and received the consequence because he failed to follow staff directions. FC #1 had an incident at school and the Licensee/QP added that to the consequence for more punishment. - FC #1's home visits were restricted because of his behavior. She said "[Licensee/QP] didn't want him down here (at her home.)" - FC #1 said he was angry with the Residential Director because his home visits were taken. - She reported the client sustained a bruise on his arm after the restraint. - FC #1 was afraid after the Residential Director restrained him. He said the Residential Director told him he did not listen to orders and did not abide by the rules. - Staff did not follow the client's treatment plan and allow the client time and space alone as defined in his treatment plan. - Staff did not check the client after the restraint to determine if he sustained any injuries. She			

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V 513	Continued From page 12 took a picture of the client's bruise when she picked him up for discharge from the facility. During interview on 12/4/18, the Residential Director confirmed: - He did not see any bruises on the client after the restraint or at any time prior to his discharge. - He did not complete a status check of the client to determine if any injury occurred and/or confirm the client was not in physical discomfort.	V 513		