

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/10/2019
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NAME OF PROVIDER OR SUPPLIER JUST IN TIME YOUTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 432 WEST 5TH STREET BURLINGTON, NC 27215
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow survey was completed on May 10, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following services category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement strategies to address the needs and behaviors for one of three clients (#1). The findings are:</p> <p>Review on 5/9/19 of client #1's record revealed: -Admission date of 3/5/18. -Diagnoses of Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Impulse Disorder and Visual Motor Delays. -Individualized Service Plan dated 6/7/18 for client #1 had no strategies to address elopement from the facility.</p> <p>Review of facility records on 5/8/19 revealed: -Incident reports for client #1 had the following information: (1). 4/5/19-"....[Client #1] ran to a neighbor house and staff utilize the assistant walk technique and walked client back to the house." (2). 12/5/18 Client #1 went out the window of the group home. The local police department was called. The police officers located client #1 and returned him to the group home.</p> <p>Interview with client #1 on 5/10/19 revealed: -He thought he eloped from the facility 2-3 times. -Police officers did return him to the facility 1-2 times. -He would normally elope to an area in the neighborhood. -He thought his last elopement was about one month ago.</p> <p>Interview with the House Manager on 5/9/19 revealed: -He thought client #1 had eloped from the facility</p>	V 112		

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V 112	<p>Continued From page 2</p> <p>2-3 times.</p> <ul style="list-style-type: none"> -He thought the most recent elopement was around January 2019. -He was not sure if the police were called during those elopement incidents. -Client #1 would normally just leave the home and walk down the street. -He confirmed client #1 had no strategies to address his elopement from the facility. <p>Interview with the Program Manager on 5/8/19 revealed:</p> <ul style="list-style-type: none"> -He thought client #1 had eloped from the facility about two times. -Client #1 also walked off from staff while in the community yesterday. -Staff did call the police during those elopement incidents. -Client #1 would normally leave the home and walk down the street. -He confirmed client #1 had no strategies to address his elopement from the facility. <p>Interview with the Licensee on 5/10/19 confirmed:</p> <ul style="list-style-type: none"> -Client #1 had no strategies to address his elopement from the facility. 	V 112		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p>	V 118		

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V 118	<p>Continued From page 3</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the physician's orders for two of three clients (#1 and #2). The findings are:</p> <p>a. Review on 5/9/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> -Admission date of 3/5/18. -Diagnoses of Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Impulse Disorder and Visual Motor Delays. -Physician's order dated 4/24/19 for Melatonin 10 mg, one tablet at bedtime. 	V 118		

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V 118	<p>Continued From page 4</p> <p>-The April 2019 MAR indicated medication was not administered 4/25 through 4/29.</p> <p>b. Review on 5/9/19 of client #2's record revealed:</p> <p>-Admission date of 5/5/18.</p> <p>-Diagnoses of Mild Intellectual Disability, Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder.</p> <p>-Physician's order dated 10/9/18 for Mobic 7.5 mg, one tablet two times daily.</p> <p>-Physician's order dated 10/8/18 for Seroquel 200 mg, one tablet at bedtime.</p> <p>-Physician's order dated 8/22/18 for Paxil 40 mg, one tablet each morning and Lithium Carbonate 300 mg, one capsule two times daily.</p> <p>-The January 2019 MAR indicated medication was not administered during the following times: Mobic 7.5 mg on 1/14 and 1/15 both dosing times; Paxil 40 mg on 1/15 and 1/17 through 1/28; Lithium Carbonate 300 mg 1/22 through 1/28 AM doses and 1/21 through 1/28 PM doses and Seroquel 200 mg on 1/26 through 1/28.</p> <p>Interview with the Home Manager on 5/9/19 revealed:</p> <p>-Client #2 had his appointment rescheduled because they were late for his appointment.</p> <p>-They were late because another client was having a crisis.</p> <p>-The medical office rescheduled the appointment for client #2 about two weeks later.</p> <p>-Client #2 ran out of some of his medications for almost two weeks.</p> <p>-He thought client #1 was out of the Melatonin because a preauthorization by the physician was needed.</p> <p>-He confirmed staff failed to follow the physician's orders for clients' #1 and #2.</p>	V 118		

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V 118	Continued From page 5 Interview with the Licensee on 5/9/19 revealed: -She knew that staff were having issues getting preauthorizations for medications. -She was not aware clients were running out of medications. -She confirmed staff failed to follow the physician's orders for clients' #1 and #2.	V 118		