STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 An annual and complaint survey was completed on 5/10/19. The complaint was unsubstantiated (intake #NC00151036). Deficiencies were cited. This facility is licensed for the following service 10A NCAC 27G.1700 Residential Treatment Staff Secure for Children and Adolescents.	V 000		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 1	V 112		

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:

Review on 5/9/19 of client #1's record revealed:
-Admission date of 10/31/18.
-Diagnoses of Autism Spectrum Disorder, Major Depressive Disorder, Conduct Disorder, Attention Deficit Hyperactivity Disorder and Generalized Anxiety Disorder.
-17 years old.
-Comprehensive Clinical Assessment dated 3/26/19-Client #1 had a history of walking away from placements, sexually aggressive behaviors, destruction of property and physical aggression.
-Person Centered Plan dated 11/1/18 for client #1 had no strategies to address elopement from the facility.

Review of facility records on 5/8/19 revealed:
-Incident reports for client #1 had the following information:
(1). 5/10/19"Staff was reading [client #1] academic sheet and observed [client #1] made several inappropriate remarks at school, staff asked [client #1] what did he say that was disrespectful and [client #1] stated he made a comment about porn but he didn't direct the comment at no one. Staff informed [client #1] he was going to call teacher and investigate incident. [Client #1] replied why, you don't believe me , I'm tired of you f******g people I'm gone, staff prompted [client #1] not to go out facility and [client #1] ran out door, staff followed [client #1] and called non-emergency number to inform of [client #1] absent and give description of [client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 2 #1] dress. Staff notified [supervisor of client] unauthorized leave, staff remain on call in case of [client #1] return." (2). 4/29/19-"Staff was on shift after previous unexplained absence from [Client #1], when local law enforcement return [client #1] to facility. Staff notified parent and immediate supervisor of [Client #1] return and was instructed to transport [client #1] to [Local Hospital] to be evaluated due to absence and lack of medication being administered due to client being out of facility. [Client #1] had been off his medications for 48 hours. Staff transported [client #1] to Hospital for assessment and [client #1] was admitted for further observation. [Client #1] remained in Hospital until 4-28-19 when [House Manager] picked him up from hospital and returned [client #1] to facility with discharge instructions. Staff transported [client #1] to [Local behavioral health agency] on 4-29-19 for follow up appointment with [License Professional]. [Client #1] was seen and transported to school without further incident." (3). 4/26/19-"Staff monitored [client #1] return from being AWOL (away without leave) from facility and his return by Police. [Client #1] stated soon as he takes a shower he is leaving and there is nothing staff can do to stop him. [Local Police] informed client if he keeps running away he can be arrested , [client #1] replied I turn 18 in 2 months and you have to release me so do what you got to do, I'm good. Staff attempted to de-escalate the situation by encouraging [client #1] to comply with treatment and medication management, staff informed him being off his medications is dangerous. Staff prompted [client #1] to not exit facility and [client #1] walked out the door stating catch me if you can, staff called local law enforcement, [clients guardian], and	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 3 [supervisor]. Staff feels [client #1] needs to be assessed to determine mental stability at this time due to not taking medication while absent from facility, [client #1] has not returned at this time." (4). 4/25/19-"Staff informed [client #1] of recent home visit events that he cannot go home due to violent outburst with guardian and destruction of property. Staff prompted [client #1] to decrease his aggressive behaviors. [Client #1] stated he has nothing to lose he is leaving facility, staff attempt to de-escalate situation by speaking in low non-threatening tone. [Client #1] walked out back door, staff followed still encouraging [client #1] to rethink his actions. Staff notified [Director], [guardian for client #] , and local law enforcement of [client #1] actions. [Client #1] is still AWOL (away without leave) from facility at this time, local law enforcement are still looking for [client #1] and [client #1] is still listed as missing." (5). 4/23/19-"Staff prompted [client #1] to clean out van and [client #1] refused stating he tired of this place he is leaving. Staff redirected [client #1] to focus and think situation through more carefully, before reacting off impulse. [Client #1] stated he is leaving and there is nothing staff can do to stop me but call police. [Client #1] ran out the door and down the street towards park. Staff called non-emergency number and reported client to authorities. [Local Police] called staff at 11:45pm to inform staff [client #1] was at [local restaurant] in [Name of city], staff went to [local restaurant] and transported [client #1] back to facility. [Client #1] came in and went to bed without further report." Review of facility records on 5/10/19 revealed: -There were police reports that responded with all of the above episodes of elopement for client #1.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 4 Interview with client #1 on 5/8/19 revealed: -He eloped from the home several times in April 2019. -About a week or two ago towards the end of April he ran about 3-4 times in one day. -He would sometimes visit family in the area or just hang out. -He just recently ran with a client from another home. -They walked to a local restaurant and decided to call the police after they arrived. -He did not have a good feeling about being at that local restaurant. -The police had located him several times while he was out in the community. -Towards the end of April he went to the hospital after eloping from the home. -He was not sure how many days he was in the hospital and/or the reason he was in the hospital. Interview with the House Manager on 5/10/19 revealed: -He thought client #1 ran away from the home about three times. -When he had the elopement episode towards the end of April 2019 he ran several times in one day. -Client #1 would elope, return to the home and elope again. -He thought he stayed out overnight during that elopement episode. -He did go to the hospital after that incident for about two days. -He thought he went to the hospital because he was not taking his medication due to the elopement. -Client #1 would normally tell them he was leaving and just walk out the door. -Staff were required to call the police each time	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 5	V 112		

client #1 elopes from the facility.
-He confirmed client #1 had no strategies to address his elopement from the facility.

Interview with the Program Director on 5/8/19 and 5/10/19 revealed:
-He thought client #1 started running away from the home in April, 2019.
-He thought client #1 eloped from the home about three times.
-The police department was called each time client #1 walked away.
-During one of client #1's elopement incidents staff took him to the hospital after he returned.
-He thought client #1 possibly went to the hospital because he was not taking his medication.
-He thought client #1 was gone for a day or two during that elopement incident.
-Client #1 actually called the police himself during one of his elopement incidents.
-Client #1 had eloped with another client and they went to a local restaurant.
-Client #1 called the police and the police department informed staff of client #1's whereabouts.
-Staff went to Hooters and returned client #1 to the group home.
-Client #1 got in trouble at school on 5/9/19.
-Client #1 left the group home on 5/9/19 after school around 6:00 PM.
-The police department was contacted on 5/9/19 and informed client #1 had eloped from the facility.
-As of 5/10/19 client #1 remains on the run and the police officers had not located him.
-Client #1 would normally tell staff he was leaving.
-Client #1 would just walk out the door.
-He confirmed client #1 had no strategies to address his elopement from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 6 Interview with the Licensee on 5/9/19 revealed: -Client #1 was previously at her group home. -Client #1 left her group home because he required a higher level of care. -Client #1 went to a Psychiatric Residential Treatment Facility (PRTF) due to the incidents of elopement. -Client #1 contacted her after he was discharged from the PRTF and wanted to return to her facility. -Client #1 begin to elope again in April 2019. -She thought client #1 had eloped from the home about 2-3 times. -Staff were required to call the police each time client #1 eloped. -The police department had an issue with them calling each time a client eloped. -The police department felt like they should "restrain" clients if they try to leave the facility. -She had told the police department staff can't put their hands on a client if they wanted to elope. -She confirmed client #1 had no strategies to address his elopement from the facility. Review on 5/10/19 of a Plan of Protection written by the Program Director dated 5/10/19 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "[Program Director] will contact [Licensed Professional] to provide a safety plan for [client #1] to address issues of [client #1] running away from facility." Describe your plans to make sure the above happens: "Treatment Team will address additional strategies and goals to put in treatment plan to help [client #1] develop positive strategies to decrease/eliminate running away from facility as a option when frustrated or upset." Client #1 had a history of elopement from	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 112	Continued From page 7 facilities. There were four documented incidents of elopement involving client #1 between April and May 2019. Client #1 ran away from the home as recently as 5/9/19 and his whereabouts are still unknown. The police department were contacted each time client #1 eloped from the facility. The Licensee indicated client #1 was discharged from her facility previously due to consistent episodes of elopement. Although the Licensee was aware of client #1's elopement history she failed to have strategies in his treatment plan to address Client #1's elopements. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (4) A Medication Administration Record (MAR) of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 8 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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the physician's orders for three of four current clients (#1, #2 and #3) and one of one former client (FC #5). The findings are: a. Review on 5/8/19 of client #1's record revealed: -Admission date of 10/31/18. -Diagnoses of Autism Spectrum Disorder, Major Depressive Disorder, Conduct Disorder, Attention Deficit Hyperactivity Disorder and Generalized Anxiety Disorder. -Admission Assessment dated 11/1/18 indicated client #1 had lost several family members and exhibited signs of grief. He had issues managing anger and history of assaultive behaviors. -Physician's order dated 2/6/19 for Zyprexa 10 mg, one tablet two times daily. Zyprexa used to treat Schizophrenia and manic episodes of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 9 Bipolar Disorder. -Physician's order dated 2/6/19 for Claritin 10 mg, one tablet daily. Claritin used to treat allergy symptoms. -Physician's order dated 1/9/19 for Melatonin 3 mg, two tablets at bedtime. Melatonin used for sleep and other sleep disorders. -Physician's order dated 1/9/19 for Kapvay ER 0.1 mg, two tablets once daily at bedtime. Kapvay used to treat symptoms of Attention Deficit Hyperactivity Disorder. -Physician's order dated 12/17/18 for Minocycline 100 mg, one capsule two times daily. Minocycline used to treat infections. -The April 2019 MAR indicated the following medications were not administered to client #1: Claritin 10 mg on 4/16 and Melatonin 3 mg on 4/1 through 4/4. -The March 2019 MAR indicated the following medications were not administered to client #1: Claritin 10 mg on 3/28; Zyprexa 10 mg on 3/28 and 3/29 AM doses and 3/27,3/28 PM doses; Minocycline 100 mg on 3/23 through 3/29 AM doses and 3/23 through 3/28 PM doses; Melatonin 3 mg on 3/22 through 3/28. -The February 2019 MAR indicated the following medications were not administered to client #1: Zyprexa 10 mg on 2/23 through 2/25 AM doses and 2/23, 2/24 PM doses. -The January 2019 MAR indicated the following medications were not administered to client #1: Kapvay ER 0.1 mg on 1/1 and 1/2; Zyprexa 10 mg on 1/18 through 1/24 AM doses and 1/18 through 1/23 PM doses; Minocycline 100 mg on 1/16 through 1/21 AM doses and 1/16 through 1/20 PM doses. b. Review on 5/8/19 of client #2's record revealed: -Admission date of 11/7/18.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 10 -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Reactive Attachment Disorder-inhibited type and Cone-Rod Dystrophy. -Admission Assessment dated 11/7/18 indicated client #2 exhibits verbal and physical aggression. He has poor impulse control, poor insight and poor judgement. -Physician's order dated 2/6/19 for Zoloft 100 mg, one tablet two times daily. Zoloft used to treat depression, Obsessive Compulsive Disorder, Panic Disorder and Post Traumatic Stress Disorder. -Physician's order dated 2/6/19 for Risperdal 1 mg, one tablet two times daily. Risperdal used to treat Schizophrenia, Bipolar Disorder and irritability associated with Autism. -Physician's order dated 2/6/19 for Catapres 0.2 mg, one tablet two times daily. Catapres used to treat anxiety. -Physician's order dated 1/15/19 for Melatonin 5 mg, two tablets at bedtime. Melatonin used for sleep and other sleep disorders. -Physician's order dated 12/13/18 for Doxycycline Hyclate 100 mg, one tablet daily. Doxycycline Hyclate used to treat and prevent infections. -Physician's order dated 11/7/18 for Wellbutrin 75 mg, one tablet two times daily. Wellbutrin used to treat depression. -Physician's order dated 11/17/18 for Cogentin 0.5 mg, one tablet two times daily. Cogentin used to treat symptoms of involuntary movements due to side effects of certain psychiatric drugs. -The March 2019 MAR indicated the following medications were not administered to client #2: Melatonin 5 mg on 3/22 through 3/29; Doxycycline Hyclate 100 mg on 3/17 and 3/18; Cogentin 0.5 mg on 3/17 through 3/28 AM doses and 3/16 through 3/26 PM doses; Catapres 0.2 mg on 3/12 through 3/15 AM doses and 3/11	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 11 through 3/15 PM doses. -The February 2019 MAR indicated the following medications were not administered to client #2: Cogentin 0.5 mg on 2/10 through 2/12 AM and PM doses; Catapres 0.2 mg on 2/3 through 2/9 AM doses and 2/2 through 2/7 PM doses; Zoloft 100 mg on 2/21 through 2/28 AM doses and 2/21 through 2/27 PM doses; Risperdal 1 mg on 2/11, 2/12 AM doses and 2/11 PM dose; Melatonin 5 mg on 2/18. -The January 2019 MAR indicated the following medications were not administered to client #2: Zoloft 100 mg on 1/20, 1/21 AM doses and 1/19, 1/20 PM doses; Cogentin 0.5 mg on 1/5 through 1/10 AM doses and 1/5 through 1/9 PM dose; Wellbutrin 75 mg on 1/1 through 1/9 AM doses and 1/1 through 1/8 PM doses. c. Review on 5/8/19 of client #3's record revealed: -Admission date of 7/10/18. -Diagnoses of Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. -Admission Assessment dated 7/10/18 indicated client #3 had a history of property destruction, running away, aggression, stealing and being impulsive. -Physician's order dated 2/4/19 for Vyvanse 70 mg, one capsule in the morning. Vyvanse used to treat Attention Deficit Hyperactivity Disorder. -Physician's order dated 2/4/19 for Lithium Carbonate ER 450 mg, one tablet two times daily. Lithium Carbonate ER used to treat Manic Depressive Disorder. -Physician's order dated 2/4/19 for Seroquel 25 mg, one tablet at bedtime. Seroquel used to treat Schizophrenia, Bipolar Disorder and Depression. -The March 2019 MAR indicated the following medications were not administered to client #3:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 12 Vyvanse 70 mg on 3/7 through 3/11; Lithium Carbonate ER 450 mg on 3/7 through 3/11 AM doses and 3/6 through 3/11 PM doses; Seroquel on 3/9 and 3/10. d. Review on 5/8/19 of FC #5's record revealed: -Admission date of 4/29/16. -Diagnoses of Mild Intellectual Disability, Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Bipolar Disorder and Attention Deficit Hyperactivity Disorder. -Discharged from home March 2019. -Admission Assessment dated 4/29/16 indicated FC #5 had a history of physical and verbal aggression, self harm and property destruction. -Physician's order dated 2/20/19 for Flonase 0.05% nasal spray, one spray per nostril daily. Flonase used to relieve seasonal and year round allergic and non-allergic nasal symptoms. -Physician's order dated 2/19/19 for Remeron 45 mg, one tablet at bedtime. Remeron used to treat Depression. -Physician's order dated 8/18/17 for Haldol 10 mg, one tablet three times daily. Haldol used to treat Psychotic Disorders. -The March 2019 MAR indicated the following medications were not administered to FC #5: Remeron 45 mg on 3/6 and 3/7; Haldol 10 mg on 2/6-8AM/2PM doses and 2/5 8 PM dose. -The February 2019 MAR indicated the following medication was not administered to FC #5: Flonase 0.05% nasal spray on 2/5 through 2/16. Interview with client #1 on 5/8/19 revealed: -He ran out of medication a couple of times. -Staff had to get a doctor's order to get a refill on his medication. -He also missed medications sometimes if he was on the run. -He gave no specifics on the type of medications	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 13 and how may times the issue occurred. Interview with client #2 on 5/8/19 revealed: -He did run out of medication a few times. -He ran out of medication because staff failed to get his medications refilled. -He gave no specifics on the type of medications and how many times the issue occurred. Interview with the House Manager on 5/8/19 and 5/10/19 revealed: -Clients' #1, #2, #3 and FC #5 ran out of medications between January and April 2019. -A preauthorization by the physician was required by the pharmacy in order to refill the medications -Sometimes there was a delay by staff getting a client's physician to send the preauthorization to the pharmacy. -He confirmed staff failed to follow the physician's orders for clients' #1, #2, #3 and FC #5. Interview with the Program Director on 5/8/19 and 5/10/19 revealed: - Staff did not consistently administer medications to clients' #1, #2, #3 and FC #5. -Clients' #1, #2, #3 and FC #5 ran out of medications. -Some of the clients had a medication management agency "that could be difficult to deal with." -Staff would often have difficulty getting medications refilled. -Most of the time staff had to wait for the physician to send a preauthorization to the pharmacy. -Clients were running out of medications due to delay of the preauthorization being sent to the pharmacy. -He confirmed staff failed to follow the physician's orders for clients' #1, #2, #3 and FC #5.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 14 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. -The House Manager was the person responsible for making sure medication orders were refilled properly. -She confirmed staff failed to follow the physician's orders for clients' #1, #2, #3 and FC #5. Review on 5/10/19 of a Plan of Protection written by the House Manager dated 5/10/19 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "Staff will implement medication management strategy of contacting all doctors, therapist or any individual that writes prescriptions for client at start of order and re-order 14 day in advance or request 3 month supply of all med (medications) with exception of control drugs." Describe your plans to make sure the above happens: "All medications will be logged and check on daily shift change, and sign off with each staff coming on shift or off shift. All orders will be ordered in timely manner. Staff will document medications well before getting low and reorder according to control policy." Staff consistently failed to ensure prescribed medications were refilled for clients' #1, #2, #3 and FC #5 within a timely manner and as ordered. There was a delay with staff requesting a preauthorization by a clients physician in order for the pharmacy to refill the prescribed medications. Clients' #1, #2, #3 and FC #5 ran out of medications between the months of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 118	Continued From page 15 January 2019 and April 2019. The majority of the medications prescribed for clients' #1, #2, #3 and FC #5 were to help manage their behaviors and mental health symptoms. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. No administrative penalty has been assessed. If the violation is not corrected within 23 days, an administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 118		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 536	Continued From page 16 course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 536	Continued From page 17 outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 536	Continued From page 18 need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six audited staff (The Qualified Professional) had training on the use of alternatives to restrictive interventions prior to providing services. The findings are: Review on 5/10/19 of the facility's personnel files revealed:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 536	Continued From page 19 -The Qualified Professional had a hire date of 11/1/14. -The Qualified Professional had a North Carolina Interventions Core Training Part A certificate that expired on 9/30/18. -There was no documentation that the Qualified Professional had current training on the use of alternatives to restrictive interventions. Interview with the Licensee on 5/10/19 revealed: -Her agency uses North Carolina Interventions Plus training on the use of alternatives to restrictive interventions. -The Qualified Professional works for another agency and received her training with that agency. -She thought the Qualified Professional had the "ProACT" training on the use of alternatives to restrictive interventions. -She did not have the Qualified Professional trained in North Carolina Interventions Plus. -She did not realize all staff were required to have the same type of training on the use of alternatives to restrictive interventions. -She confirmed there was no documentation of training on the use of alternative to restrictive intervention for the Qualified Professional.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 537	Continued From page 20 staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 537	Continued From page 21	V 537		

incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualification and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 537	Continued From page 22 observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 537	Continued From page 23 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six audited staff (The Qualified Professional) had training in the use of seclusion, physical restraints and isolation time-out. The findings are: Review on 5/10/19 of the facility's personnel files revealed: -The Qualified Professional had a hire date of 11/1/14. -The Qualified Professional had a North Carolina Interventions Core Training Part B certificate that expired on 9/30/18. -There was no documentation that the Qualified Professional had training in the use of seclusion, physical restraints and isolation time-out. Interview with the Licensee on 5/10/19 revealed: -Her agency uses North Carolina Interventions Plus training in the use of seclusion, physical restraints and isolation time-out. -The Qualified Professional works for another agency and received her training with that	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-149	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	1710 SYKES STREET 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 537	Continued From page 24 agency. -She thought the Qualified Professional had the "ProACT" training in the use of seclusion, physical restraints and isolation time-out. -She did not have the Qualified Professional trained in North Carolina Interventions Plus. -She did not realize all staff were required to have the same type of training in the use of seclusion, physical restraints and isolation time-out. - She confirmed there was no documentation of training in the use of seclusion, physical restraints and isolation time-out for the Qualified Professional.	V 537		