Division of Health Service Regulation

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A.BUILDING: (X3) DATE SURVEY COMPLETED

	ROVIDER OR SUPPLIER		RESS CITY	STATE, ZIP CODE	
		1710 SYKE			
UST IN 1	TIME YOUTH SERVICES	BURLINGT	ON, NC 27	/215	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	,	V 000 V		
	An annual and complaint survey was com on 11/4/21. The complaint was unsubstan (intake #NC00182002). Deficiencies were This facility is licensed for the following s category: 10A NCAC 27G .1700 Residen Treatment Staff Secure for Children or Adolescents.	ervice			
V 500		TS blicy 122C-	V 500	During the next JITYS clients rights committee meeting. Policy on Rights Restrictions and Interventions will be discussed pertaining to locks on closets, while clients are out of the facility, and procedures staff and clients for unlocking the closets when they	
	abuse, neglect or exploitation of clients reported to the County Department of S Services as specified in G.S. 108A, Artic or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medic practice when a medication that is known present serious risk to the client is prescril Particular attention shall be given to the us neuroleptic medications.	ocial cle 6 cal to bed.		return to the facility, whether it's from school, group home outings, o home visits.	r
	 (c) In addition to those procedures prohi 10A NCAC 27E .0102(1), the governin of each facility shall develop and imp policy that identifies: (1) any restrictive intervention that i prohibited from use within the facility; and (2) in a 24-hour facility, the circums under which staff are prohibited from rest the rights of a client. (d) If the governing body allows the use 	g body olement is d stances tricting			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DTGL11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A.BUILDING:

	MHL001-149	B.WING		11/04/2021
	TIME YOUTH SERVICES 1710 SYK	DRESS, CITY, ST ES STREET TON, NC 272		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
V 500	Continued From page 1 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, 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.	V 500		
vision of H	This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to implement interventions to address behaviors which did not restrict the rights for one of three clients (#1). The findings are: ealth Service Regulation			

Division of Health Service Regulation STATE FORM

If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A.BUILDING: (X3) DATE SURVEY COMPLETED

	MHL001-149			11/04/2021
IAME OF P		DRESS, CITY, ST	TATE, ZIP CODE	
JUST IN	TIME YOUTH SERVICES	ES STREET		
		TON, NC 272		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
V 500	Continued From page 2	V 500		
	Observation of facility on 11/3/21 at approximately 2:35 pm revealed: -Client #1 and client #2's bedroom-There was a lock on client #1's closet. Client #1's clothing was in the locked closet. Review on 11/3/21 of General Statue 122C-62 revealed "A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional (QP) at least every seven			
	days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's records." Review on 11/3/21 of client #1's record revealed: -Admission date 4/29/21. -Diagnoses of Disruptive Mood Dysregulation			
	Disorder, Mild Intellectual Disability, Autism, Attention Deficit Hyperactivity Disorder and Post Traumatic Stress Disorder. -Date of birth was 11/30/10. -There was no evidence of a written statement for client #1 detailing restrictions of personal possessions or evidence of an evaluation of			
	each restriction reviewed at least every seven days by the Qualified Professional.			
	Interview on 11/3/21 with the Home Manager revealed: -Client #1's closet was locked because he would smear feces on his clothing. -She thought client #1 was admitted to the facility earlier this year.			
ision of H	-They started locking his closet as soon as he ealth Service Regulation			

If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A.BUILDING:

		MHL001-149	B.WING		11/04/2021
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 SYKES STREET BURLINGTON, NC 27215			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED E REGULATORY OR LSC IDENTIFYING INFORI	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
V 500	Continued From page 3 was admitted around March or April 2 She did not realize locking client #1's in the closet was considered a rights restrictionShe confirmed client #1's were being restricted. Interview on 11/4/21 with the Program Director revealed: -The agency had been locking personal items for a while. -The agency did not meet with the hun rights committee prior to locking up cl clothingHe confirmed client #1's right being restricted.	clothes rights up clients man ent #1's	V 500		