Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	LIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL001-169	B. WING		R 03/04/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CIT	Y, STATE, ZIP CODE	
			NOOD DR	IVE	
JUST IN	TIME YOUTH SERVIC		TON, NC	27215	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
V 000	INITIAL COMMEN	TS	V 000		
		w up survey was completed 22. Deficiencies were cited.		RECEIVED By cvhicks at 3:45	pm, May 25, 2022
	category: 10A NCA	sed for the following service AC 1300 Residential Treatment en and Adolescents.	t		
		ed for 6 beds and currently The survey sample consisted nt clients.			
V 179	27G .1301 Resider	itial Tx - Scope	V 179		
	residential treatmen residential treatmen service. (b) A residential residential treatmen licensed as set fort (c) A residentia and adolescents is facility which provid environment within children or adolesc diagnosis of menta disturbance and wh disabilities. (d) Services sh functioning level of include training in s skills, social skills, a Children or adolesc day treatment facili attend school. (e) Services sh child or adolescent	301 SCOPE f this Section apply only to a nt facility that provides nt, level II, program type al treatment facility providing nt, level III service, shall be h in 10A NCAC 27G .1700. al treatment facility for children a free-standing residential les a structured living a system of care approach for ents who have a primary l illness or emotional no may also have other he child or adolescent and self-control, communication and recreational skills. cents may receive services in a ty, have a job placement, or hall be designed to support the in gaining the skills necessary ural, or therapeutic home			

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

Division of Health Service Regulation

STATE FORM	N		6899 L	JDLZ11	If continuat	ion sheet 1 of 3			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
					R	l			
		MHL001-169	B. WING		03/0/	4/2022			
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
JUST IN	111 DOGWOOD DRIVE JUST IN TIME YOUTH SERVICES II								
			TON, NC 27	2215					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE			
V 179	Coordinate with othe within the client's sy This Rule is not me on record review ar failed to coordinate individuals and age system of care, affe clients (Client #2 ar are: Review on 2/24/22 -Admission date of -Diagnosis of Mariju Schizophrenia Spec Disorder Interview on 2/24/2 -He had therapy we The clients from oth sessions at the grou- After therapy sessi computer for school Interview on 2/25/2 The therapy sessio computer. -Clients had therap weekly. -Since the homes e	et as evidenced by: Based nd interviews, the facility care with other encies within the client's exting 2 of 3 audited nd Client #3). The findings of Client #2 record revealed: 12/20/21. Jana Abuse, Unspecified ctrum and Other Psychotic 2 with Client #2 revealed: eekly on the computer her homes also had their up home. ion were done, he logged on al. 2 with the Director revealed: - ns were held virtually on the y sessions at the home engage in social activities	V 179	DEFICIENCY) Group Home meet with therapist to establish a time schedule for thera will allow the group home to hold o therapy sessions within the home t eliminate the agency intermixing of from different levels of care during sessions.	py that lients to f clients				
		was OK they had therapy ome as long as staff was							

Division of Health Service Regulation Division of Health Service Regulation

STATE FOR	N		6899 L	JDLZ11	If continuation sheet 2 of
STATEMENT OF DEFICIENCIES AND (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
					R
		MHL001-169	B. WING		03/04/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
			NOOD DRIV	E	
JUST IN	TIME YOUTH SERVIC		TON, NC 27	7215	
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORRECTIO	DN (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 179	Continued From pa	ige 2	V 179		
	Continued From page 2 -Confirmed that facility failed to coordinate care within the client's system of care. Review on 2/24/22 Client #3 record revealed: -Admission date of 4/30/19. -Diagnoses of Mild Intellectual Developmental Disability, Autism Spectrum, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder- combined presentation. Interview on 2/24/22 with Client #3 revealed: - He had therapy on the computer with the therapist. -Other clients from other group homes used computer for their therapy sessions. -After therapy session, he was transported to school. Interview on 2/25/22 with the Director revealed: - The therapy sessions were held virtually on the computer. -Clients had therapy sessions at the home weekly. -Since the homes engage in social activities together, thought it was OK they had therapy sessions at same home as long as staff was present with clients. -Confirmed that facility failed to coordinate care within the client's system of care.				