Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
AND FLAN OF CORRECTION		IDENTIFICATION NOWIBER.	A. BUILDING: _	JILDING:		-120
MHL001-149		B. WING		C 05/16/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
JUST IN T	IME YOUTH SERVICES	1710 SYKE BURLINGT	S STREET ON, NC 27215	3		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	A complaint survey was completed on May 16, 2023. The complaint (intake #NC00201409) and (Intake #NC00201614) were unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents The facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 2 current clients, 1 former client.					
V 132	G.S. 131E-256(G) HO Allegations, & Protect		V 132			
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care					

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		С	
		MHL001-149			05/1	6/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
JUST IN T	IME YOUTH SERVICES		ON, NC 2721	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	facility or to a patient e. Fraud against a h a patient or client for providing services). Facilities must have acts are investigated to protect residents fr investigation is in pro- investigations must be	or client. ealth care facility or against whom the employee is evidence that all alleged and must make every effort om harm while the gress. The results of all e reported to the e working days of the initial	V 132			
	failed to assure an all reported to the Health (HCPR) nor did the fa	ew and interview, the facility egation of abuse was n Care Personal Registry acility initate a plan of clients while an investigation				
	revealed no allegation reported to the HCPR	R. FC#1's record revealed:				

Division of Health Service Regulation

STATE FORM 6899 GODC11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	COMPLETED	
						С	
MHL001-149		B. WING		05	16/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
		1710 SYF	(ES STREET				
JUST IN T	IME YOUTH SERVICES	BURLING	TON, NC 2721	5			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE	
V 132	Continued From page	2	V 132				
	Diamaga of Candu	at Diagraday					
	-Diagnoses of Condu	e, Unspecified Trauma and					
		rder, Provisional Disruptive					
		Disorder, High Risk Sexual					
	Behavior, Child Sexu	. 0					
	Subsequent Encount						
	Relational Problem.	or and raiont orma					
	-Involuntary Commitn	nent 4/15/23.					
	-Discharged 4/15/23.						
	-FC#1 reported allegations to the Police on 4/22/23.						
	Review on 5/9/23 of t	he Police Report Narrative					
	Review on 5/9/23 of the Police Report Narrative dated 4/22/23 revealed: -"On 4/22/23, at approximately 1933 (7:33 p.m.), [Officer] responded to [County Hospital] for a						
		[Officer] spoke with [FC#1]					
	who stated that he ha	id been sexually and					
	physically assaulted a	at the Just in Time Youth					
	Services home. This	interview took place at the					
		avioral health unit where					
		d. [FC#1] stated that a male					
		approached [FC#1] when					
		stay at the home. This					
		und the end of March. [Staff					
		s] room to speak with him.					
		as in a room that had two					
	_ = =	the only staying in the the bed nearest to the back					
		window. [Staff #2] sat on					
	the bed nearest to the						
		a joke that he described as,					
	"inappropriate." [FC#1] stated that he did laugh						
		then bent over to tie his					
		at down next to [FC#1] on					
	I	en put his hand on [FC#1's]					
	_ =	1] if he was gay. [FC#1]					
		sexual but had not publicly					
		nation and did not feel					
comfortable discussing it with [Staff #2]. [Staff							

Division of Health Service Regulation

STATE FORM 6899 GODC11 If continuation sheet 3 of 6

PRINTED: 05/19/2023 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				COMPLETED	
		A. BUILDING:			
				С	
		MHL001-149	B. WING		05/16/2023
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AS	DRESS, CITY, STA	TE 710 000E	
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	II E, ZIP CODE	
JUST IN T	IME YOUTH SERVICES		ES STREET	_	
		BURLING	TON, NC 2721	5	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	
iAG		,	IAG	DEFICIENCY)	
V 400	0 (; 15	0	V 422		
V 132	Continued From page	3	V 132		
	#2] told [FC#1] that he	e was gay. [FC#1] stated			
	that he froze, but eve	ntually told [Staff #2] to stop.			
	-A couple of days afte	er the incident, [Staff #2]			
	approached [FC#1] a	gain in his room. [Staff #2]			
	began to take his han	d and feel [FC#1's] thigh.			
	[FC#1] stated that he	was wearing pants that had			
	a button on them, but	that it did not actually			
	button. [Staff #2] tried	d unbuttoning his pants,			
	realized he did not ne	ed to, then slipped his hand			
	down [FC#1's] pants.	[Staff #2] then began to			
	fondle [FC#1's] penis[FC#1] could not give much detail about what exactly had occurred. Whenever [FC#1] would begin to discuss what happened, he would hide				
	his face and cry. [FC#1] stated that he had not				
		to anyone because he did			
	not want to cause pro	blems. [FC#1] stated that			
	he froze due to being	previously raped.			
		information to [Officer],			
		uss a separate incident in			
		/ee [Staff #1] had physically			
	assaulted him. [FC#1	=			
		re he had been committed			
		3. [Staff #1] told [FC#1] that			
		ch his room for something.			
	,	ed [FC#1] while he was on			
		rearm on [FC#1's] neck.			
		[FC#1] up and threw him			
		#1] stated that he hit part of			
		he wood broke. [FC#1]			
		sk leg and was going to pick			
	it up and use it against [Staff #1] but [Staff #1]				
		ounched him in the eye. At			
		unched [FC#1] in the arm.			
		that he hit him because			
		nit him first. [FC#1] stated			
	_	FC#1] to run away and that			
		assault other kids as well.			
		I the name of the other			
victim. [FC#1] was able to provide much more		1			

Division of Health Service Regulation

STATE FORM 6899 GODC11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE		
AND FLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COM	COMPLETED	
						С	
MHL001-149		B. WING		05/	16/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
			KES STREET	,			
JUST IN T	IME YOUTH SERVICES		STON, NC 27215	;			
0.40.1=	CLIMMA DV CT		· ·		OF CORRECTION	0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
V 132	Continued From page	2 4	V 132				
	detail about this assault than he was about the sexual assault. -[FC#1] stated that he had been punched in the right eye. [Officer] could not see any obvious injuries to [FC#1's] eye. [FC#1] also had bruises to his left arm. One bruise was closer to his shoulder and other closer to his bicep. [FC#1] stated that he had frequently reported physical abuse to his mother but had only just told her today about the sexual abuse. -[Officer] checked with medical personnel to see if [FC#1] had entered the hospital with injuries. None of [FC#1's] records noted any obvious injuries upon his arrival. [FC#1] did have a history of self-harm."						
	"Interview with [FC#1's] mother: -[Officer] spoke with [FC#1's] mother, over the phone. [FC#1's] mother stated that [FC#1] had called her approximately 20 times that day. [FC#1's] mother suspected that [FC#1] was upset because it was [FC#1's] grandmother's birthday and she was getting a lot of attention. [FC#1's] mother stated that [FC#1] would make up stories to make himself the center of attention. The final time [FC#1] called [FC#1's] mother, [FC#1] disclosed that he had been sexually assaulted[FC#1's] mother stated that [FC#1] had described the suspect that had sexually assaulted him as an 18-year-old boy who lived in the group home. [FC#1] stated that this suspect was not an employee, but also not a patient. [FC#1] had given [FC#1's] mother a name of the suspect, but she could not remember it[FC#1's] mother stated that she was not sure whether the sexual assault allegations were true, but she thought that the physical assault allegations were. [FC#1] had run away from the group home and stated that, the reason why						

Division of Health Service Regulation

STATE FORM 6899 GODC11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION (X3) DATE SUR COMPLETI		
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MHL001-149		MHL001-149	B. WING		1	6/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
JUST IN T	ME YOUTH SERVICES		S STREET	_		
(VA) IB	SHIMMARY ST	ATEMENT OF DEFICIENCIES	ON, NC 27218	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	Continued From page	: 5	V 132			
V 132	[FC#1's] mother state able to live with her at mental health issues attempts, [FC#1] was -[Officer] explained to would be an investiga [FC#1's] mother had referred for the following of the foll	d that [FC#1] wanted to be thome but due to [FC#1's] and past homicidal not allowed to. [FC#1's] mother that there tion into [FC#1's] allegation. not seen [FC#1] since in to the hospital, so she r [FC#1] had arrived with led to [County Hospital] to to [Cou	V 132			

Division of Health Service Regulation

STATE FORM 6899 GODC11 If continuation sheet 6 of 6