Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-253	A. BUILDING: ______ B. WING ______	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	**432 WEST 5TH 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 July 10, 2023. The complaint was substantiated (intake #NC00204254). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	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	DHSR - Mental Health NOV 2 2023 Lic. & Cert. Section	

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This Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to develop and implement strategies to meet the needs affecting one of three audited clients (#1). The findings are:

Review on 7/6/23 of client #1's record revealed:
-Admission date of 12/8/20.
-Diagnoses of Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment and Asthma.
-He was 18 years old.
-Trauma Intensive Comprehensive Clinical Assessment dated 1/8/21-He had a history arguing with authority figures or adults, bullying/threatening behaviors, non-consensual sexual behavior (exposing himself), property destruction and threatening others with a weapon.
-Individualized Support Plan (ISP) dated 3/1/23 had no strategies to address walking away from the facility unsupervised.

Review on 7/5/23 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:
-6/13/23-"[Client #1] is persistent to speed the

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process of his transition plan. [Client #1] wanted to leave the group home without permission. [Client #1] refused to listen to staff trying to discourage his decision to want to leave the group home. [Client #1] walked out the door, and the police was called, as well as his social worker."
-3/27/23-"[Client #1] was telling other clients because he is 18, he can leave the group home because he was grown. Staff expressed to [client #1] that just because he's 18 doesn't mean he can just do what he wants too, especially when it comes to living the group home. Staff explained to [client #1] that he was to walk out the door and leave the premises. Then staff would have to call the police. [Client #1] stated that well I'm 18 and I'm leaving. Staff called the non-emergency number. The police department caught up with [client #1] approximately half mile from the group home at church..."
-8/13/22-"While staff was completing his daily routine check on client, he noticed [client #1] as not in his room, and his back door was open. Staff looked in all the rooms. as well as outside the facility and didn't see [client #1]. staff then contacted the on call manager and inform them that [client #1] eloped from the facility. The manager then contacted the non emergency police department and informed them of [client #1's] elopement as well as where he typically goes when he eloped from the group home. Approximately 10-15 mins (minutes) later [Name of city] police department contacted the manager inform him that they have found [client #1] and will be taking him to the hospital to me evaluated..."

Review on 7/6/23 of police reports from the local police department for client #1 revealed:
-6/26/23-The Chief Executive Officer/Qualified

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Professional (CEO/QP) reported client #1 walked away from the facility unsupervised. She reported client #1 left at 8:20 pm. Client #1 was entered into National Crime Information Center (NCIC) as a missing person. Client #1 returned to the facility around 10:12 pm and was taken out of NCIC.
-5/26/23-The Program Director reported client #1 walked away from the facility unsupervised.
-3/28/23-The Program Director reported client #1 walked away from the facility unsupervised. A police officer responded to the facility at 5:55 pm in reference to client #1 being missing. Client #1 was entered into the NCIC. At 9:12 pm, another police officer "advised via communication" that he was out with client #1 at the local police department. Client #1 told the police officer he had been walking in the area and spending time at a church.

Review on 7/6/23 of the NC Center for Missing Persons online website revealed:
-An alert was activated for client #1 on 6/14/23 at 10:46 am.

Observation on 7/10/23 of the local community near the facility at approximately 9:50 am revealed:
-Route from the facility to the local train station had posted speed limits along roads that ranged between 35 to 20 miles per hour.
-Road near train station had a posted speed limit of 20 miles per hour.

Review on 7/7/23 of the google maps application (app) revealed:
-Walk on foot from the facility to the train station was approximately .07 miles and a 16-minute walk.
-Local train station to other city's train station where client #1 eloped was approximately 21.7

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miles and a 30-minute drive by train.

Interview on 7/6/23 with client #1 revealed:
-He left the facility on 6/13/23 unsupervised and walked to the local train station.
-He lived at a facility in another city in the past and was familiar with the area.
-He decided he wanted to catch the train to that other city.
-He did not have any money and a stranger at the train station bought him a ticket to that other city where he used to reside.
-When he arrived to the other city, he walked around for a little while.
-He slept at a homeless shelter every night he was in that other city.
-When he was in the other city he asked strangers at different stores or restaurants to buy him food because he had no money.
-A few days after being in the other city Police Officers approached him on the street.
-Those Police Officers told him he would be going back to the facility where his group home was located.
-He was in the other city until 6/16/23.
-He left the facility again about a week and ½ later towards the end of June 2023.
-On that day he walked to a local restaurant in the area and asked a stranger to buy him food.
-He did not stay out long when he left towards the end of June 2023 because he heard thunder.
-He returned to the facility on his own without police officers picking him up.
-Between January 2023 and June 2023, he left the facility unsupervised "about" five times.
-Sometimes when he left, he did ask strangers to buy him food.
-He also ran away a few times in 2022. He was not sure how many times he ran.
-Police Officers brought him back to the facility

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V 112	Continued From page 5 several times when he left unsupervised. -He would tell staff he was leaving and just walk out the front or back door. -Staff told him not to leave and "I just keep on walking." -"Staff may follow me for a block or two sometimes, but I walk fast and staff can't keep up with me." Interview on 7/6/23 with staff #1 revealed: -Client #1 walked away during his shift once. -He left the facility unsupervised at the beginning of June 2023. -The police department was called during that incident. Interview on 7/6/23 with staff #2 revealed: -Client #1 left the facility unsupervised several times over the last 6 months while he was working. -He was not sure how many times client #1 left within those 6 months. -Client #1 left the facility towards the end of June 2023 most recently. -He called the CEO/QP when client #1 left the facility. -The CEO/QP contacted the police department to report client #1 missing. Interview on 7/7/23 with client #1's Department of Social Services (DSS) guardian revealed: -She became client #1's guardian in February 2023 once he turned 18. -According to his Teachers and Care Coordinator client #1 had a lengthy history of elopement from facilities. -She was informed client #1 would normally run during the summer, however he ran from the facility a few times in March 2023. -Client #1 ran away from the facility several times	V 112		

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since she took over his case in February 2023.
-Staff from the facility contacted her each time client #1 ran.
-She thought client #1 ran 6 or 7 times and staff called the police each time client #1 ran.
-Whenever she would ask client #1 why he was running, "he would tell me he was 18 and could do whatever he wanted to do."
-Client #1 would tell her he was grown.
-Client #1 also told her he was tired of living at the facility with children.
-"[Client #1] could be impulsive and although he was 18 his functioning level was that of an 11-year-old."
-She was aware of the incident on 6/13/23 when client #1 left the facility unsupervised and took a train to another city.
-The Program Director called her shortly after client #1 left the facility.
-A Detective with the local police department was working with them on the missing person case with client #1.
-The Detective sent her some "picture still videos" of client #1 from the train station purchasing a ticket.
-The Detective also looked at the manifest from the train station and was informed client #1 took a train to another city.
-She sent two of her DSS co-workers to the other city and they found client #1 within 30 minutes.
-The co-workers found client #1 near the train station in the other city with homeless people.
-The other city's police department was contacted and they escorted client #1 back to the local city on 6/16/23.
-When she talked to client #1 about going to the other city, he told her he had been hanging out with homeless people while he was there.
-Client #1 said he slept at a homeless shelter in the other city.

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-He said some homeless people were helping him out while he was in the other city.
-Client #1 told her "homelessness is freedom."
-"[Client #1] thinks being homeless is cool."
-Whenever client #1 would run away from the facility, he told her he was begging strangers for food or money.
-She knew he begged because every time she visited him at the facility, client #1 asked her for money.
-Client #1 could have just eaten at the facility. Client #1 would leave the facility and ask strangers in the community for food.
-Client #1 ran away from the facility since the 6/13/23 incident.
-Client #1 ran away on 6/26/23 and staff from the facility contacted her.
-She talked to client #1 about that incident and he said he asked strangers to buy him food while he was in the community.
-Client #1 said a male bought him food from a local restaurant and also gave him money.
-Client #1 said he wasn't out that long when he walked away that time because he was afraid of a thunderstorm.

Interviews on 7/5/23 and 7/10/23 with the Program Director revealed:
-On June 13, 2023 client #1 left the facility and walked down the road headed towards the police station.
-"He told [client #1] not to leave the facility and he left anyway."
-He called the police department "immediately" to report client #1 left the facility unsupervised.
-He was working alone with other clients during that incident and did not follow client #1 when he left the facility unsupervised.
-They were told later client #1 went to the train station and asked for a ticket.

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V 112	Continued From page 8 -A stranger bought client #1 a ticket and he went to another city. -A silver alert was issued on 6/15/23 for client #1. -On 6/16/23 client #1's guardian texted him and said client #1 was found in another city. -Client #1 had been with them for over a year. -Client #1 started running last year with a former client. -Client #1 did stop running at one point and started running again. -"[Client #1] turned 18 and felt like he could do what he wanted to do." -Client #1 would tell them "I'm grown and don't have to listen to anybody." -"[Client #1] felt like because he is 18 he can make his own decisions." -Staff always called the police department when client #1 left the facility unsupervised. -Between January and June 2023, he thought client #1 left the facility 4-5 times. -Client #1 would normally stay away from the facility for about half hour to an hour. -Facility staff did participate in the plan meetings with the Local Management Entity/Managed Care Organization (LME/MCO). -The LME/MCO was responsible for developing the goals and strategies in client #1's ISP. -He confirmed client #1 had no strategies to address walking away from the facility unsupervised. Interview on 7/5/23 with the CEO/QP revealed: -She was called by the Program Director on 6/13/23 and he reported client #1 left the facility unsupervised. -The Program Director was working alone and did not follow client #1. -She found out later when client #1 left the facility, he walked to the train station. She was told a person in the community bought client #1 a train	V 112		

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V 112	Continued From page 9 ticket. -She was told client #1 was seen near a homeless shelter in another city. -Client #1 returned to the facility on 6/16/23. -Client #1 did run again after that incident, however he was gone for only a few minutes because there was a storm outside. -Client #1 left the facility on several occasions. -She thought client #1 lived at the facility for about 2 ½ years. -She noticed client #1 liked to leave the facility during the summer. -She was not sure how many times client #1 left unsupervised since living at the facility. -Staff would sometimes follow client #1 for a few blocks if there were 2 staff working together. -Client #1 would pack his bag and say he was leaving. -"Now that [client #1] is 18, you can't tell him anything, he is going to do what he is going to do." -Staff called the police department as soon as client #1 left the facility. -"The LME/MCO did his plan and the LME/MCO was responsible for his plan." -She confirmed client #1 had no strategies to address walking away from the facility unsupervised. Review on 7/10/23 of a Plan of Protection written by the Program Director dated 7/10/23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Facility will contact [Client #1's Guardian] and LME (Local Management Entity) to updated and revise client's treatment plan to address concerns of client's elopement. Describe your plans to make sure the above happens. During all future treatment plan meeting the service provider will ensure the all concerns and behaviors are	V 112		

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V 112	Continued From page 10 address in the treatment plan." Client #1 was 18 years old and his diagnoses included: Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment and Asthma. On 6/13/23 client #1 left the facility unsupervised and walked to the local train station. A train ticket was purchased for client #1 by a stranger at the train station. Client #1 took the train from the local city to another city that was approximately 21.7 miles and 30 minutes via train. Client #1 was found in the other city on 6/16/23 by DSS staff near a train station in the company of homeless people. The other city's police officers returned client #1 to the facility on 6/16/23. Within the last 10 months client #1 had 6 documented incidents of walking away from the facility unsupervised. Client #1 had no strategies to address walking away from the facility unsupervised. 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 $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and	V 114		

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V 114	Continued From page 11 shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure disaster drills were done quarterly on each shift. The findings are: Review on 7/6/23 of the facility's disaster drill log revealed: -There was only one drill completed for the 2nd quarter 2023. -The 7am to 7pm shift failed to complete a drill for the 1st quarter of 2023. Interviews on 7/6/23 with clients' #1 and #3 revealed: -They did disaster drills with staff. -He was not sure how often the drills were done. Interview on 7/5/23 with client #2 revealed: -He was not sure if they ever did any disaster drills with staff. Interview on 7/6/23 with staff #2 revealed: -He has been working at the facility for 1 year and 8 months. -He worked 7pm to 7am.	V 114		

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V 114	Continued From page 12 -He never did any fire or disaster drills during his shift. Interview on 7/6/23 with the Program Director revealed: -There were two separate staff shifts. -Staff worked 7am-7pm and 7pm-7am. -He had been checking the drills for this facility since other management staff left in January 2023. -He thought staff were completing disaster drills for this facility. -He confirmed staff failed to conduct disaster drills quarterly on each shift.	V 114		
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 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;	V 118		

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JUST IN TIME YOUTH SERVICES	432 WEST 5TH STREET BURLINGTON, NC 27215

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(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 interview, the facility failed to keep the MAR current affecting two of three audited clients (#1 and #3). The findings are:

Review on 7/6/23 of client #1's record revealed:
-Admission date of 12/8/20.
-Diagnoses of Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment and Asthma.
-He was 18 years old.
-Physician's orders dated 5/5/23 for Atomoxetine 60 milligrams (mg) (ADHD), one capsule daily.

Review on 7/6/23 of the June 2023 MAR for client #1 revealed:
-There were no staff initials on 6/28 thru 6/30 for Atomoxetine 60 mg to indicate that medication was administered.

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V 118	Continued From page 14 Review on 7/6/23 of client #3's record revealed: -Admission date of 8/10/20. -Diagnoses of Mild Intellectual Disability, Bipolar Disorder-Unspecified, Allergic Rhinitis, Eczema and Allergic Conjunctivitis. -He was 14 years old. -Physician's order dated 4/26/23 for Qelbree 200 mg (ADHD), 2 capsules at bedtime. Review on 7/6/23 of the July 2023 MAR for client #3 revealed: -There were no staff initials 7/1 thru 7/5 for Qelbree 200 mg to indicate that medication was administered. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Interview on 7/6/23 with the Program Director revealed: -Staff possibly forgot to sign off on the MAR to indicate the medication was administered for client #1. -He thought "staff over looked signing off on the Qelbree because the administration time was not written on grid of MAR." -"The Qelbree medication was available and staff administered that medication to [client #3]." -He confirmed facility staff failed to keep the MARs current for clients' #1 and #3.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the	V 121		

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governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated.
(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to obtain drug regimen reviews every six months for three of three audited clients (#1, #2 and #3) who received psychotropic drugs.
The findings are:

Review on 7/6/23 of client #1's record revealed:
-Admission date of 12/8/20.
-Diagnoses of Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder (PTSD), Fetal Alcohol Syndrome, Reactive Attachment and Asthma.
-He was 18 years old.
-Physician's order dated 5/5/23:
Atomoxetine 60 milligrams (mg) (ADHD), one capsule daily
Clonidine 0.1 mg (ADHD), one tablet in the morning and two tablets at bedtime.
Risperidone 1 mg (Bipolar Disorder), one tablet in the morning and two tablets at bedtime.
Sertraline 50 mg (PTSD), one tablet daily

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V 121	Continued From page 16 Equetro 300 mg (Bipolar Disorder), one capsule twice daily Aripiprazole 10 mg (Bipolar Disorder), one tablet at bedtime -Drug regimen review was completed on 10/19/22. -There was no documentation of a drug regimen review completed within the last six months. Review on 7/6/23 of Medication Administration Records (MARs) revealed: -July 2023-Staff documented client #1 was administered the above medications July 1-5. -June 2023-Staff documented client #1 was administered the above medications for the month. -May 2023-Staff documented client #1 was administered the above medications for the month. Review on 7/6/23 of client #2's record revealed: -Admission date of 7/2/22. -Diagnoses of Severe Intellectual Disability, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder with Depressed Mood and Congenital Heart Murmur. -He was 17 years old. -Physician's order dated 4/28/23: Atomoxetine 40 mg, one capsule in the morning Divalproex Extended Relief (ER) 250 mg (Bipolar Disorder), one tablet in the morning Olanzapine 7.5 mg (Bipolar Disorder), one tablet at bedtime Divalproex ER 500 mg, one tablet at bedtime Olanzapine 2.5 mg, one tablet twice a day -Drug regimen review was completed on 10/19/22. -There was no documentation of a drug regimen review completed within the last six months.	V 121		

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V 121	Continued From page 17 Review on 7/6/23 of MARs revealed: -July 2023-Staff documented client #2 was administered the above medications July 1-5. -June 2023-Staff documented client #2 was administered the above medications for the month. -May 2023-Staff documented client #2 was administered the above medications for the month. Review on 7/6/23 of client #3's record revealed: -Admission date of 8/10/20. -Diagnoses of Mild Intellectual Disability, Bipolar Disorder-Unspecified, Allergic Rhinitis, Eczema and Allergic Conjunctivitis. -He was 14 years old. -Physician's order dated 4/26/23: Quetiapine 300 mg (Bipolar Disorder), two tablets at bedtime Bupropion 150 mg (Depression), two tablets in the morning Amitriptyline 25 mg (Depression), one tablet at bedtime Lamotrigine 150 mg (Bipolar Disorder), one tablet twice daily Fanapt 8 mg (Schizophrenia), one tablet twice daily Qelbree 200 mg (ADHD), 2 capsules at bedtime -Drug regimen review was completed on 10/19/22. -There was no documentation of a drug regimen review completed within the last six months. Review on 7/6/23 of MARs revealed: -July 2023-Staff documented client #3 was administered the above medications July 1-5. -June 2023-Staff documented client #3 was administered the above medications for the month.	V 121		

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V 121	Continued From page 18 -May 2023-Staff documented client #3 was administered the above medications for the month. Interviews on 7/6/23 and 7/10/23 with the Program Director revealed: -The drug regimen reviews were not completed for 2023. -They were last done October 2022 for all three clients. -The Former Qualified Professional was responsible for the drug regimen reviews when he was employed at the facility. -The Former Qualified Professional did not ensure those drug regimen reviews were completed for those clients. -He confirmed there was no documentation of a drug regimen review completed for clients' #1, #2 and #3 within the last six months.	V 121		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as	V 289		

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V 289	Continued From page 19 designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as	V 289		

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V 289	Continued From page 20 alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure minor and adult clients did not reside in the same facility affecting four of four clients (#1, #2, #3 and #4). The findings are: Review on 7/6/23 of client #1's record revealed: -Admission date of 12/8/20. -Diagnoses of Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment and Asthma. -He was 18 years old. Review on 7/6/23 of client #2's record revealed: -Admission date of 7/2/22. -Diagnoses of Severe Intellectual Disability, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder with Depressed Mood and Congenital Heart Murmur. -He was 17 years old. Review on 7/6/23 of client #3's record revealed: -Admission date of 8/10/20. -Diagnoses of Mild Intellectual Disability, Bipolar Disorder-Unspecified, Allergic Rhinitis, Eczema and Allergic Conjunctivitis.	V 289		

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V 289	Continued From page 21 -He was 14 years old. Review on 7/6/23 of client #4's record revealed: -Admission date of 4/7/23. -Diagnoses of Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder. -He was 9 years old. Review on 7/5/23 of the facility's license revealed: -The facility was licensed as a 5600B - Supervised Living for Minors with Developmental Disability with a capacity of 4 clients effective 1/1/23. Observations on 7/5/23 and 7/6/23 of the facility revealed: -Clients #1, #2, #3 and #4 were all present at the facility. -Client #1 was an adult client residing with three minor clients. Interviews on 7/5/23 and 7/10/23 with the Program Director revealed: -Client #1 was turned 18 years old at the beginning of February 2023. -He thought client #1 could remain in the facility until he completed school for the year. -His guardian requested they keep client #1 at this facility until their adult group facility opens. -They are in the process of getting an adult facility licensed and client #1 was supposed to be moving into that facility. -The facility was supposed to be opening in April 2023, however there were some set backs getting the facility licensed. -He confirmed the facility failed to ensure minor and adult clients did not reside in the same facility.	V 289		

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V 366	Continued From page 22	V 366		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

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V 366	Continued From page 23 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

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available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level II incidents as required. The findings are:

Review on 7/6/23 of client #1's record revealed:
-Admission date of 12/8/20.
-Diagnoses of Mild Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment and Asthma.
-He was 18 years old.

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V 366	Continued From page 25 Review on 7/6/23 of police reports from the local police department for client #1 revealed: -6/26/23-The Chief Executive Officer/Qualified Professional reported client #1 walked away from the facility unsupervised. She reported he left at 8:20 pm. Client #1 was entered into National Crime Information Center (NCIC) as a missing person. Client #1 returned to the facility around 10:12 pm and was taken out of NCIC. -5/26/23-The Program Director reported client #1 walked away from the facility unsupervised. -3/28/23-The Program Director reported client #1 walked away from the facility unsupervised. A police officer responded to the facility at 5:55 pm in reference to client #1 being missing. Client #1 was entered into the NCIC. At 9:12 pm, another police officer "advised via communication" that he was out with client #1 at the local police department. Client #1 told the police officer he had been walking in the area and spending time at a church. Reviews on 7/5/23 and 7/6/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There were no Level II incident reports submitted by the facility when the local police department was contacted due to client #1 leaving the facility unsupervised on 6/26/23, 5/26/23 and 3/28/23. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures.	V 366		

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V 366	Continued From page 26 Interview on 7/10/23 with the Program Director revealed: -Reports were not done in IRIS for some of those incidents when client #1 walked away from the facility. -The reports were not done because client #1 was gone for 30 minutes or less. -They did call the police during those incidents when client #1 left the facility unsupervised. -He confirmed the facility failed to implement a policy governing their response to Level II incidents as required.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-253	A. BUILDING: ______ B. WING ______	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST IN TIME YOUTH SERVICES	432 WEST 5TH STREET BURLINGTON, NC 27215

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V 367	Continued From page 27 cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall	V 367		

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V 367	Continued From page 28 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Refer to V-366 regarding implementing a policy governing their response to Level II incidents. -Facility staff called the police department to report client #1 left the facility unsupervised on 6/26/23, 5/26/23 and 3/28/23. -Review of the North Carolina Incident Reporting Improvement System (IRIS) revealed the Program Director failed to report the above	V 367		

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V 367	Continued From page 29 incidents to the LME/MCO within 72 hours.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. The findings are: Observation on 7/5/23 of the facility at approximately 1:15 pm revealed: -Client #2's bedroom-One of the windows was covered by a sheet of plexiglass with screws placed over the entire window. The window could not be opened. The 2nd window had a piece of plywood on the outside towards bottom portion that was approximately 12 feet by 4 inches wide. The 2nd window also had a sheet of plexiglass on the inside of the window towards middle portion that did not cover the entire window. This window could not be opened by the Program Director until he took a screwdriver and removed a screw from the metal panel of the window sill. The window opened approximately 8-10 inches and was then closed by the Program Director. The Program Director tried to open the window again and the window would not open. There was peeling paint around the window sills. -Bathroom #2-There was a strong urine smell. Border near floor of shower was cracked. Tile on wall of shower had peeling paint. Bottom panel of	V 736		

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V 736	Continued From page 30	V 736		

window was missing and replaced with a piece of plywood on the outside that was approximately 12 feet by 4 inches wide.
-Carpet in the hallway had a tear that was approximately 15 inches long.
-Clients' #1 and #3's shared bedroom-There was a sheet of plexiglass with screws placed over 3 separate windows. All three of those windows were covered entirely with a sheet of plexiglass and those windows could not be opened.
-Client #4's bedroom- There was a sheet of plexiglass with screws placed over 2 separate windows. Both windows were covered entirely with a sheet of plexiglass and those windows could not be opened. There was spackling paste on 4 separate areas of the wall. There were approximately 25 nail holes in the wall. There was no curtain or blinds over one of the windows.
-Common area-Two of the blind slats were missing. Eight of the blind slats were broken on the edges.
-Dining room area-One set of blind slats had a broken edge. The second set of blinds had 2 slats broken on the edge. The third set of blinds had 2 slats broken towards middle of blinds. The area rug was buckled.

Interview on 7/6/23 with client #1 revealed:
-The plexiglass had been over the windows in their bedroom for over a year.
-"I feel like staff put plexiglass over the windows to keep clients from going out the window."
-He went out the window in his bedroom a few times prior to the plexiglass being placed over the windows.

Interview on 7/6/23 with client #3 revealed:
-The plexiglass had been over the windows for about a year.
-He was told by staff the plexiglass was over their

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER: **JUST IN TIME YOUTH SERVICES**

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V 736	Continued From page 31	V 736		

windows because other clients tried to go out the window to leave the facility.

Interview on 7/6/23 with staff #1 revealed:
-The plexiglass was over the windows in client bedrooms due to former client (FC) #5 busting out the windows.
-The Chief Executive Officer/Qualified Professional (CEO/QP) was "constantly" replacing windows throughout the facility.
-The plexiglass was over client's bedroom windows for about a year.

Interview on 7/5/23 with the Program Director revealed:
-He was aware of the maintenance issues with the facility.
-FC #5 busted the windows out in the client bedrooms.
-They would move FC #5 into a different bedroom. FC #5 would bust out the windows in that bedroom.
-They decided to put plexiglass over all of the windows in client's bedrooms because they were "constantly" replacing windows in the facility.
-The plexiglass had been over those windows for over a year.
-"We never really thought about removing the plexiglass after [FC #5] left the facility."
-He confirmed the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.

Interview on 7/5/23 with the CEO/QP revealed:
-She was aware there was plexiglass over all the windows in all the clients' bedrooms.
-Clients had been busting out the windows in their bedrooms.
-It was mainly FC #5 busting out windows when he lived at the facility.

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V 736	Continued From page 32	V 736		

-Client #1 busted out the window in the bathroom and fell out the window when he left the facility on one occasion.
-She was not sure how long the plexiglass was over those windows in the clients' bedrooms.
-She replaced glass panels in those windows on several occasions.
-"I spent a lot of money in the past because I was constantly replacing the glass panels in the window sills."
-She decided to put plexiglass over the windows to keep clients from busting out the windows in those bedrooms.
-She confirmed the facility was not maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.

Review on 7/10/23 of a Plan of Protection written by the Program Director dated 7/10/23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The plexi-glass will be removed immediately to eliminate any fire or safety issues. Describe your plans to make sure the above happens. Just In Time Youth Services will re-figure a method to cover glass without preventing exit from facility in case of fire or emergency."

Clients' #1, #2, #3 and #4's diagnoses included: Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Disruptive Mood Dysregulation Disorder, Conduct Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome, Reactive Attachment, Oppositional Defiant Disorder, Adjustment Disorder with Depressed Mood, Congenital Heart Murmur and Asthma. Their ages ranged from 9 to 18 years old. There were sheets of plexiglass covering the entire window in 2 of the client

Division of Health Service Regulation

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V 736	Continued From page 33 bedrooms and those windows could not be opened. The 3rd bedroom had one window covered entirely by a sheet of plexiglass and could not be opened. The other window in the 3rd bedroom was partially covered by a sheet of plexiglass. The windows in all three bedrooms had plexiglass over them for at least a year. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 736		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

July 19, 2023

Lisa Brown
Just In Time Youth Services
P.O. Box 2162
Burlington, North Carolina 27216

RE: Type A1 Administrative Penalty
Just In Time Youth Services, 432 West 5th Street, Burlington, NC 27215
MHL # 001-253
E-mail Address: ncbrownie2@yahoo.com

Dear Ms. Brown:

Based on the findings of this agency from a survey completed on July 10, 2023, we find that Just In Time Youth Services has operated Just In Time Youth Services in violation of North Carolina General Statute (N.C.G.S.) § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities, and Substance Abuse Services. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A1 administrative penalty of $2,000.00 against Just In Time Youth Services for violation of 10A NCAC 27G .0206 Assessment/Treatment/Habilitation Plan (V112). A Type A1 administrative penalty of $5,000.00 was also assessed for violation of 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Payment of the penalty is to be made to the Division of Health Service Regulation and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 10% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of

Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Julie Cronin, General Counsel. This person may receive service of process by mail at the following address:

Ms. Julie Cronin, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 919-630-5591 within thirty (30) days from the date of this letter. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Renee Kowalski, Eastern Branch Manager at 919-630-5591.

Sincerely,

Robin Sulfridge, Chief
Mental Health Licensure & Certification Section

Cc: dhsrreports@dhhs.nc.gov
Medicaid.dhsr.notice@dhhs.nc.gov
accreditationNotifications@nctracks.com
dhhs@vayahealth.com
DHSRreports@eastpointe.net

_DHSR_Letters@sandhillscenter.org
Candice Gobble, Director, Alamance County DSS
Pam Pridgen, Administrative Supervisor

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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July 19, 2023

Lisa Brown
Just In Time Youth Services
P.O. Box 2162
Burlington, NC 27216

Re: Annual and Complaint Survey completed July 10, 2023
Just In Time Youth Services, 432 West 5th Street, Burlington, NC 27215
MHL # 001-253
E-mail Address: ncbrownie2@yahoo.com
Intake #NC00204254

Dear Ms. Brown:

Thank you for the cooperation and courtesy extended during the Annual and Complaint survey completed 7/10/23. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation(s) are cited for 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V-112), 10A NCAC 27G .0303 Facility and Grounds Maintenance (V-736)
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is 8/2/23. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Just In Time Youth Services for each day the deficiency remains out of compliance.

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 9/8/23.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

dhhs@vayahealth.com
DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Candice Gobble, Director, Alamance County DSS
Pam Pridgen, Administrative Supervisor