			(X3) DATE SURVEY COMPLETED				
			A. BUILDING: _				
			B WING		С		
		MHL001-149	B. WING		04/09/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
1710 SYKES STREET							
JUSTINI	IME YOUTH SERVICES	BURLING	STON, NC 27215	5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)		
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			
V 000	INITIAL COMMENTS		V 000				
		as completed on April 9, was unsubstantiated (intake iencies were cited.					
	<u>-</u>	d for the following service 27G .1900 Psychiatric t for Children and					
	<u>-</u>	d for 4 and has a current rey sample consisted of ents.					
V 132	G.S. 131E-256(G) HC Allegations, & Protect		V 132				
	REGISTRY	LTH CARE PERSONNEL					
		es shall ensure that the d of all allegations against l, including injuries of					
	any act listed in subdi (which includes:	ch appear to be related to vision (a)(1) of this section.					
		of a resident in a healthcare whom home care services					
	as defined by G.S. 13	1E-136 or hospice services 11E-201 are being provided.					
	in a health care facility	of the property of a resident y, as defined in subsection uding places where home					
	care services as defin hospice services as d	ned by G.S. 131E-136 or lefined by G.S. 131E-201					
	are being provided. c. Misappropriation of healthcare facility.	of the property of a					
	facility or to a patient	s belonging to a health care or client. ealth care facility or against					

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

TITLE (X6) DATE

NAME OF PROVIDER OR SUPPLIER JUST IN TIME YOUTH SERVICES (X4) ID PREFIX TAG (SACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 132 Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER JUST IN TIME YOUTH SERVICES 1710 SYKES STREET BURLINGTON, NC 27215 C(A) D	AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED		
SUMMARY STATEMENT OF DEFICIENCIES BURLINGTON, NC 27215		MHL001-149		B. WING		_	
SUST IN TIME YOUTH SERVICES BURLINGTON, NC 27215	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CX4 ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) COMPLETE DATE V 132	ILIOT IN T	IME VOLITIL CEDVICES	1710 SYKE	S STREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 132 Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings	JUSTINI	IME YOUTH SERVICES	BURLINGT	ON, NC 2721	5		
a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COM	PLETE
are: Review on 4/3/25 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for an allegation of abuse against the facility staff related to the 4/1/25 incident with client #1. Interview on 4/9/25 with the Qualified Professional (QP) revealed: -"The [Program Director] and the [Owner] completes all documentation of any incidents in the facility." -"I'm not sure if the [Program Director] or the [Owner] reported the incident to HCPR." Review on 4/2/25 and Review 4/9/25 with the Program Director revealed: -"I did not report the incident to HCPR, and I did not complete the IRIS report." -"It was so much going on that I forgot to do the report."	V 132	a patient or client for providing services). Facilities must have acts are investigated to protect residents frinvestigation is in project investigations must be Department within fivenotification to the Department within fivenotification t	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 partment. as evidenced by: ew and interviews, the e an allegation of abuse was are Personnel Registry orking days. The findings the North Carolina (NC) approvement System (IRIS) Il incident report submitted llegation of abuse against d to the 4/1/25 incident with ith the Qualified realed: for and the [Owner] entation of any incidents in Program Director] or the incident to HCPR." If Review 4/9/25 with the ealed: incident to HCPR, and I did is report."	V 132			

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			(X3) DATE SURVEY COMPLETED					
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		MHL001-149	B. WING	04/09/20				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
JUST IN T	IME YOUTH SERVICES		CES STREET					
		BURLING	STON, NC 27215	5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE			
V 132	Continued From page	2	V 132					
	IRIS report was comp Director] handles that -"I did not know about didn't realize we had to	PR was notified or if the leted because the [Program ." the allegation until later and to report it." and the [Program Director]						
V 367	27G .0604 Incident R	eporting Requirements	V 367					
	level II incidents, excet the provision of billable consumer is on the princidents and level II of to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the besubmitted on a for Secretary. The report in person, facsimile of means. The report shinformation: (1) reporting providentification informat (2) client identification informat (3) type of incidentification of the incident; (4) description of the cause of the incident; (6) other individent incident; (7) other individent incident;	PROVIDERS providers shall report all ept deaths, that occur during e services or while the oviders premises or level III deaths involving the clients rendered any service within cident to the LME tchment area where within 72 hours of e incident. The report shall m provided by the t may be submitted via mail, rencrypted electronic hall include the following ovider contact and ion; ication information; ent; of incident; e effort to determine the						

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1710 SYKES STREET BURLINGTON, NC 27215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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JUST IN TIME YOUTH SERVICES 1710 SYKES STREET BURLINGTON, NC 27215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	MHL001-149		B. WING		04/09/2025			
JUST IN TIME YOUTH SERVICES BURLINGTON, NC 27215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BURLINGTON, NC 27215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	ILICT IN T	TIME VOLITH SERVICES	1710 SYKE	S STREET				
(**)	JUST IN I	TIME TOUTH SERVICES	BURLINGT	ON, NC 27215	5			
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE	
V 367 Continued From page 3 V 367	V 367	Continued From page	3	V 367				
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 2EC 0.0300 and 10A NCAC 2TE 0.104(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 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident.	V 367	missing or incomplete shall submit an updat report recipients by the day whenever: (1) the provider information provided erroneous, misleading (2) the provider required on the incide unavailable. (c) Category A and B upon request by the Lobtained regarding the (1) hospital recinformation; (2) reports by 00; (3) the provider (d) Category A and B of all level III incident Mental Health, Development of the providers shall send a incidents involving a contract of the providers or restraint, the provider death within secon restraint, the provider quarterly to the catchment area where the provider shall be suby the Secretary via expectation include summary inforest.	e information. The provider ed report to all required the end of the next business. Thas reason to believe that in the report may be gor otherwise unreliable; or obtains information ent form that was previously providers shall submit, and the incident, including: ords including confidential of the authorities; and the response to the incident. Supported to the Division of the incident. Category A a copy of all level III client death to the Division of the incident. In cases of the incident of the incident of the incident of the incident. In cases of the incident of the inci	V 367				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLI	150
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
JUST IN T	IME YOUTH SERVICES	1710 SYKE				
		BURLINGT	ON, NC 27215	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	(3) searches of (4) seizures of the possession of a c (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter (a) and (d) of this Rul through (4) of this Par	el II or level III incident; a client or his living area; client property or property in lient; mber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1) ragraph.	V 367			
	facility failed to ensure the Local Managemer Organization (LME/M where services are probecoming aware of the Review on 4/3/25 of conditional control of the Review on 4/3/25 of conditional control of the Review on 4/3/25 of the Review on 4/3/25 of the Local Management of the Local Organization of the Review on 4/3/25 of the Local Management	regulation Disorder, Other eficit Hyperactivity Disorder, ems Related to Primary hild in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL001-149 B. WING		C 04/09/2025			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
JUST IN TIME YOUTH SERVICES 1710 SYKES BURLINGTO			S STREET ON, NC 27219	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 367	by the facility for an a the facility staff relate client #1. Interview on 4/9/25 w Professional (QP) rev-"The [Program Directompletes all docume the facility." -"I'm not sure if the [P [Owner] completed the Review on 4/2/25 and Program Director reve-"I did not report the inot complete the IRIS-"I did not complete the staff was listed, and I-"It was so much goin report." Review on 4/9/25 with -"I did not know if HC IRIS report was comp Director] handles that -"I did not know about didn't realize we had	Il incident report submitted llegation of abuse against d to the 4/1/25 incident with with the Qualified realed: tor] and the [Owner] entation of any incidents in trogram Director] or the e IRIS report. If Review 4/9/25 with the ealed: ncident to HCPR, and I did is report." ne IRIS report because no didn't know how to fill it out." g on that I forgot to do the enterprise or the objected because the [Program c." the allegation until later and to report it." and the [Program Director]	V 367				

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