

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL090-202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/21/2022
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NAME OF PROVIDER OR SUPPLIER LUCILLE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1402 LUCILLE AVENUE MONROE, NC 28112
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(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	<p>INITIAL COMMENTS</p> <p>A complaint and annual survey was attempted on 9-21-22. According to the Director There are no clients being served at the facility. The last time clients were served at the facility was 7-29-22.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for four and currently has a census of zero. The survey sample consisted of one former client.</p> <p>The Director stated in her interview on 9-21-22 that they had no clients since the end of July. They were accepting referrals but the referrals they were getting were not suitable for a level III.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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