

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/21/2024
NAME OF PROVIDER OR SUPPLIER SECU YOUTH CRISIS CENTER, A MONARCH PROGR		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 BACK CREEK DRIVE CHARLOTTE, NC 28213		
(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 survey was completed on 3/21/24. The complaints were substantiated (intake #NC00214074, #NC00214080). No deficiencies were cited.</p> <p>The facility is licensed for 16 and currently has a census of 10. The 10A NCAC 27G .3100 Non-hospital Medical Detoxification-Individuals who are Substance Abusers has a current census of 0 and the 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups has a current census of 10.</p> <p>The survey sample consisted of audits of 1 former client in the Facility Based Crisis Service for Individuals of all Disability Groups.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE