PRINTED: 12/06/2024 **FORM APPROVED** 

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING MHL0601361 11/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 BACK CREEK DRIVE SECU YOUTH CRISIS CENTER, A MONARCH PROGR CHARLOTTE, NC 28213 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 A complaint survey was completed on 11-15-24. The complaints were substantiated (intake #NC00221774 and #NC00221737). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 3100 Nonhospital Medical Detoxification For Individuals Who Are Substance Abusers and 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups. RECEIVED This facility is licensed for 16 and has a current DEC 2 n 2024 census of 15. The 10A NCAC 3100 Nonhospital Medical Detoxification For Individuals Who Are Substance Abusers has a current census of 0 **DHSR-MH Licensure Sect** and the 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups has a current census of 15. The survey sample consisted of audits of 2 former clients in the 10A NCAC 5000 Facility Based Crisis Services For Individuals Of All Disability Groups. V 110 27G .0204 Training/Supervision V 110 Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, Division of Health Service Regulation

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

Beverly Hatcherbarge

Director of Operations

TITLE

12/16/2024

(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE :	SURVEY LETED
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	then qualified professis professionals shall det (e) Competence shall exhibiting core skills ir (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skills (6) communication sk (7) clinical skills. (f) The governing bod develop and implement for the initiation of the inplan upon hiring each.  This Rule is not met as Based on record review paraprofessionals (form#2) failed to demonstrate and abilities required be the findings are:  Review on 10-25-24 of -Date of hire: 11-27-23Job Title: Behavioral H-Date of termination: 9-and FC #2.  Oral/Verbal warning de (2024), [FS #1] was set the unit with people we important that [FS #1] owhen on the unit so he	ionals and associate monstrate competence. I be demonstrated by including: Ige; s;	V 110	<ol> <li>The staff involved in this in are no longer employed windonarch.</li> <li>The Program Manager will the following in-service traisessions with staff:         <ul> <li>Q15 Safety Check</li> <li>Cellphone Usage</li> <li>No Sleeping</li> </ul> </li> <li>The Director, Program Marand Nurse Manager will coutilize the weekly monitoring ensure safety is maintained</li> <li>The Director, Program Marand Nurse Manager will regreview camera footage to engoing monitoring, appropriate interactions, and consupervision.</li> <li>During monthly staff meeting Program Manager will addresseping policy, cellphone using Q15 minute safety chemical policy.</li> </ol>	conduct ning s nager, ntinue to g tool to d. nager, gularly ensure priate istent ngs, the ess the usage,	12/31/2024 Ongoing Ongoing Ongoing

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STATEMENT OF DEFICIENCIES (X1) F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED	
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seen via the cameras when an incident occi [FC #1] was then sus investigation for alleg -Termination notice da investigation was that was substantiated."  Review on 10-25-24 c -Date of hire: 6-24-24 -Job Title: Behavioral -Date of termination: 9 and FC #2Suspension notice da was discovered that 2 were in the bathroom (incorrect date on repeasleep during the incic-Termination notice daseen sleep (8-31-24) adequate supervion to which resulted in an inthe pending investigating neglect has been substamped 21-59-21 (9:3 seconds. There was responded to the vide corridor away from the (approximately 40 to 5 of a closed door on the bathrooms #1 and bathoff camera. 33 seconds seen walking from the	ated 9-3-24: "[FS #1] was (8-31-24) on is cellphone burred between two youths. pended pending ations of neglect." ated 9-11-24: "Conclusion of the allegation of Neglect  of FS #2's record revealed: Health Technician. 0-10-24 for neglect of FC #1  ated 9-4-24: "On 9-3-24 it PWS (persons we serve) together on 8-28-24 ort), {FS #2] appeared to be dent." ated 9-11-24: [FS#2] was on camera not providing of the people we support cident. The findings from ion is the allegation for stantiated.  the facility's video footage secent Exit Corridor," time 59 pm), 3 minutes and 24 no audio with the video: At eo, FC #1 walked down the enurses station 0 feet) and stopped in font	V 110			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
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	and walked towards the standing. At minute 1 right hand around FC left hand is around FC left hand is around FC FC #2 turns FC #1 around FC #2 grabbhis right hand on FC # area and bends her own bent over at her waist behind FC #1. FC #1 (she is smiling) and her FC #2 walked back do the nurses station). For the hallway but stoppedown the hall and walk area. FC #2 stopped at 1:37 FC #2 is seen through the following forms the nurses station. FC #1 was still shoth walked back down nurses station. FC #1 seet from the nurses station. FC #1 feet from the nurses station. FC #1 feet from the nurses station. FC #1 see room towards bathroor view. The video ends at -Video #2 titled "Nurse 22-6-34 (10:06 pm), 6 for There was no audio with from the inside of the number front open end of the clients and staff have a well as views of bathrooseconds into the video and FS #1 entered the room. FS #1 and FC #2 thier mouths moving as bathroom #2, opened to closed the door and stopping for the first popened to closed the door	ne area where FC #1 was :09 FC #1 is seen with her #2's upper back. FC #2's #1's waist. At minute 1:12 and to where she is facing ed FC #1's left arm, places 1's upper right shoulder wer at her waist. FC #1 is and FC #2 is standing pulled away from FC #2 elets her go. At minute 1:18 with the corridor (towards C #1 followed FC #2 down d approximately halfway sed back to the previous at the nurses station. At powing an object into the ked back down the corridor standing. FC #1 FC #2 in the corridor towards the stops approximately 5 to 10 ation then walks out of the bathroom #2. At minute in walking from the day in #2 outside the camera's at 3:23. Is station 1," time stamped minutes and 23 seconds. It the video: This view is urses station and shows the nurses station in which increases to the nurses as oms #1 and #2. At 12 FC #2 exited bathroom #2 nurses area from the day nurses area from the day	V 110			

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
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V 110	Continued From page	4	V 110	500000000000000000000000000000000000000		
	towards the nurses station with the minute 1:31 into the vi #2 and walked to the ri #1, FC #2 and the nurse and their mouths are ri #2 walked back toward FC #1 and the nurse station with the minute 2:35 FC #2 wa on the left side of the ri 3:11 FS #1 walked down the nurses station out and the nurse remained their mouths were move walked back toward back	ation and towards FS #1 at comes into the frame and FC #2 are standing at the eir mouths moving. At deo FC #1 exited bathroom nurses station. FC #1, FS se are facing each other moving. At minute 1:57 FC ds the day room. FS #1, ontinue to stand at the eir mouths moving. At lked past the open window nurses station. At minute wn the corridor away from of the camera view. FC #1 at the nurses station and ving. At minute 4:15 FC #1 atthroom #2 out of camera FC #1 entered bathroom #2 ne trashcan then exits the ed back to the nurses he nurse to hand her an at the corridor away from the amera view. At minute				
	nurses station and wair appear in the frame). A walked back down the	ts (the nurse does not at minute 5:37 FC #1				
	nurses station. Video	The state of the s				
	-Video #3 titled "Adole					
		2pm), 9 minutes and 11				
		as no audio with the video				
		ft of the nurses station with				
	3 small tables. Two bat					
	The state of the s	urses station. FS #1 and table to the far left of the				- 1
	room.	to the latter of the				
	FC #2 could be seen wa	alking between the nurses pathroom #1 and back into				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		SURVEY
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V 110	Continued From page	:5	V 110			
	the day room. FC #1 #2 at 54 seconds into walking towards bathr bathroom #1 but he cl #1. At minute 1:44 FC where FC #1 was and behind him. FS #1 is s (laid back in the chair) at a cellphone. His fin cellphone, while FS # with his head bowed, if FS #1 looks up from h moving, then he return cellphone At 5 minute video, FS #1 sits up in (uses his left hand/arm is moving. At minute 5 chair and walks toward #2 walked out of bathr towards the nurses sta passed each other. As each other their mouth 6:47 FC #1 exited bathr the nurses station. FS and around the nurses moving. At minute 7:1 FS #1 and FC #1 and v FC #2 began to assist around the day room. remained at the nurses moving until moving on 8:02 FS #2 got up from around the table he has shuffled papers that we #2 went to the far left w	the video. FC #2 is seen froom #1. He did not enter fosed the door to bathroom #2 entered, shutting the door seen sitting slightly slumped with his head down looking gers were moving over the 2 was sitting in his chair not moving. At minute 4:20 is cellphone, his mouth is as to looking at his as and 15 seconds into the his chair and gestures in to point) while his mouth 1:23 FS #1 gets up out of his dibathroom #2. At 5:25 FC froom #2 and walked from FS #1 and FC #2 from #2 and approached from #2 and approached from #3 and FC #4 were at a station with their mouths from #4 and FC #1 walked away from walked into the day room. With moving furniture FS #1 and FC #1 station with their mouths for FC #2 walked away from walked into the day room. With moving furniture FS #1 and FC #1 station with their mouths at of the cameras view. At a his chair, and moved do been sitting at and for lying on the table. FS wall where some chairs had bown in one of the chairs.	V 110			
		facility's incident reports estigation dated 9-10-24				

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STATE FORM 0NYU11 If continuation sheet 6 of 13

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1810 BACK CREEK DRIVE  CHARLOTTE, NC 28213  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X3) DATE SURVEY COMPLETED	LE CONSTRUCTION S:	A. BUIL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MENT OF DEFICIENCIES AN OF CORRECTION			
NAME OF PROVIDER OR SUPPLIER  SECU YOUTH CRISIS CENTER, A MONARCH PROGR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  COMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 6  and signed by the Director of Operations/DO that documented the following incident: "On 9-3-24 [staff #3] informed [Program Manager/PM] that [FC #1] and [FC #2] were together in the bathroom on August 31, 2024. At approximately 1:29PM, [PM] notified [DO] who was offsite of the incident and indicated he would review the camera footage. By 1:35 PM, [PM] and [Nurse Manager/NM] had reviewed the footage and confirmed the incident"  Review on 10-25-24 of the North Carolina Incident Response Improvement System (IRIS)	C 11/15/2024		B. WIN	MHL0601361				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 110  Continued From page 6  and signed by the Director of Operations/DO that documented the following incident: "On 9-3-24 [staff #3] informed [Program Manager/PM] that [FC #1] and [FC #2] were together in the bathroom on August 31, 2024. At approximately 1:29PM, [PM] notified [DO] who was offsite of the incident and indicated he would review the camera footage. By 1:35 PM, [PM] and [Nurse Manager/NM] had reviewed the footage and confirmed the incident"  Review on 10-25-24 of the North Carolina Incident Response Improvement System (IRIS)		IVE	CK CREEK	SECU YOUTH CRISIS CENTER, A MONARCH PROGR				
and signed by the Director of Operations/DO that documented the following incident: "On 9-3-24 [staff #3] informed [Program Manager/PM] that [FC #1] and [FC #2] were together in the bathroom on August 31, 2024. At approximately 1:29PM, [PM] notified [DO] who was offsite of the incident and indicated he would review the camera footage. By 1:35 PM, [PM] and [Nurse Manager/NM] had reviewed the footage and confirmed the incident"  Review on 10-25-24 of the North Carolina Incident Response Improvement System (IRIS)		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA	PRE	MUST BE PRECEDED BY FULL	X (EACH DEFICIENC)	PREFIX		
documenting the following: "It was reported that a female patient (FC #1) went into the bathroom and a male patient (FC #2) followed her. Both patients were viewed on the camera as being in the bathroom for a total of 4 minutes. One staff (FS #2) appeared to be asleep, and another staff member (FS #1) was on his cell phone."  -9-4-24 Healthcare Personnel Registry report documenting the following: "It was reported that a female patient (FC #1) went into the bathroom and a male patient (FC #2) (17 years old) followed her. Both patients (clients) were viewed on the camera as being in the bathroom for a total of 4 minutes. One staff appeared to be asleep (FS #2), and another staff member (FS #1) was on his cell phone."  Attempted interview on 11-6-24 with FS #1 was unsuccessful. Phone call and message left for FS #1 on 11-6-24 was not returned by survey exit date.  Interview on 11-6-24 with FS #2 revealed: -"I don't know what happened (8-31-24). I didn't see them (FC #1 and FC #2) go in the bathroom." -"When we (staff) are in the day room, the way			V 110	ector of Operations/DO that ving incident: "On 9-3-24 orgam Manager/PM] that ere together in the 1, 2024. At approximately [DO] who was offsite of the he would review the :35 PM, [PM] and [Nurse iewed the footage and"  If the North Carolina provement System (IRIS) initted on 9-4-24 ving: "It was reported that a went into the bathroom and in of 4 minutes. One staff is asleep, and another staff in his cell phone."  It was reported that a went into the bathroom and (17 years old) followed in the camera as being in the camera as being in the camera and the camera and the camera as being in the camera as being in the camera as being in the search of the bathroom and (17 years old) followed in the camera of the bathroom for a total of 4 weared to be asleep (FS in ember (FS #1) was on  11-6-24 with FS #1 was all and message left for FS in returned by survey exit the FS #2 revealed: pened (8-31-24). I didn't C #2) go in the bathroom."	and signed by the Dire documented the follow [staff #3] informed [Pr [FC #1] and [FC #2] w bathroom on August 3 1:29PM, [PM] notified incident and indicated camera footage. By 1 Manager/NM] had rev confirmed the incident Review on 10-25-24 or Incident Response Imprevealed a report subredocumenting the follow female patient (FC #1) and a male patient (FC #1) and a male patient (FC #1) and a male patient (FC #2) appeared to be member (FS #1) was confirmed the incident (FC #1) and a male patient (FC #1) and a male patient (FC #1) and a male patient (FC #2) her. Both patients (clied camera as being in the minutes. One staff apper #2), and another staff in his cell phone."  Attempted interview on unsuccessful. Phone compared the minutes of the minutes			

Division of Health Service Regulation

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V 110 Continued From page 7 V 110		
the day room is sat up we can see where all the clients are at all times.  -No, I wasn't sleeping. I had knee surgery, (unknown date) I had to have fluid drained off my knee. When they (supervisor) called me to come in I told them I couldn't walk, that I would have to sit down."  -"We (staff) are suppose to watch the clients to make sure they are safe. We do activities with them, play games, watch tv, talk to them help them deal with what's going on with them."  -"At the end of the shift (8-31-24), [FS #1] was doing the report and he told me that two clients were in the bathroom together but that it was an accident (FC#2 accidentally walked in on FC #1 in the bathroom). He said it was no problem, it was handled."  -"No I didn't report it because he (staff #1) said it was no problem. I didn't know anything about them (FC #1 and FC #2) being in the bathroom for a long time. [FS #1] said it was an accident."  -"Yes, policies and procedures were covered when I was hired."  Interview on 11-7-24 with staff #3 revealed:  -Worked the 7 am to 7 pm shift.  -"I came in that morning (9-1-24). We (staff) usually do like a hand off (shift report) where we update the staff coming on shift on what		
happened during the shift. [FS #1] was doing the report. He (FS#1) said the shift went good, there		
was no issues, everything was good. As he was wrapping up (the shift report), he mentioned that [FC #2] had accidentally walked in the bathroom on [FC #1]. He (FS#1) said it almost like an afterthought. He said it was no big deal that it was an accident and that it (FC#2 accidentally walked in the bathroom on FC #1) was handled. I actually didn't think anything about it because he (FS #1) wasn't reporting it like it was an incident.		

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V 110	Continued From page	8	V 110			
		walking in the bathroom on something that happened				
		was thinking to myself, n telling me this if it's not an				
	incident?"					
		went on , I started hearing on we support) (clients)				
		bout it (FC #1 and FC #2				
		together). At first they ggling about it, you know				
		ually tried to redirect them				
	and told them to stop t	alking about it. The next				
	day (9-2-24), they (clients) were still talking about it (FC #1 and FC #2 being in the bathroom					
		I was hearing that it wasn't				
	an accident. Again I g					
	_	the sex word. They were				
	be gossiping and talkir	them they really couldn't				
		at something like someone				
		om. They were saying 'no				
		#2] told them that [FC #1]				
		oral sex) in the bathroom.				
		it wasn't true (allegation				
		had sex in the bathroom).				
		nied everything. She said ying on her just trying to				
	- BETTER NO.	hat time I decided that I				
	needed to report this to					
	-Reported incident to the	he PM on 9-3-24.				
	Interview on 11-4-24 w	ith the Nurse revealed:				
	-She was the nurse on					
		nurses station. Not exactly				
		vas sometime during the #1) walked by he told me				
	that [FC #2] had accide					
	bathroom on [FC #1]."					
	-"I didn't see either of the	hem (FC #1 or FC #2) go				- 1

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
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V 110	Continued From page	9	V 110			
	into the bathroom but	I was sitting in the back of				
	the room doing docum					
		t say it like it was a problem				
	he explained that he					
		] came out and he asked				
		g and [FC #2] said he went				
		n but [FC #1] was already in				
		ened the door and [FC #1]				
	was in the bathroom."					
		d FC #2) denied anything				
		said it was an accident.				
	생물 이 사람이 가장 이렇게 되어 먹는 사람이 되었다. 그는 사람이 되었다. 그리고 그리고 있다면 하다 없다.	C #1] was in the bathroom				
		w she was in there and that				
		d she was there he left."				
		#1) about it. I asked her a				
	couple of times and sh	A				- 1
	happened	ic defiled arrything				- 1
	7. 7.	ort the incident to anyone				- 1
	because FS #1 told he					- 1
		m while FC #1 was in the				- 1
	bathroom.	II Willie I C #1 was in the				
	Datificom.					- 1
	Interview on 10 25 24	with the PM revealed:				
	-He was notified on 9-3					
	allegation that FC #1 a					- 1
	•					- 1
	unsupervised in the ba 8-31-24.	attiroom together on				- 1
		my supervisor, the DO, who				
	was off that day (9-3-2	egations. Then I contacted				
		and she and I pulled the				
		ewed the video footage and				
		nts (FC #1 and FC #2) were				
	alone in the bathroom					
		laying on his phone and				
	70	Ve immediately suspended				
	(FS#1). [FS #1] was w					
		ne came in for his shift.				
		heduled to work) so since it				
	was so late in the day v	when all this came to light,				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		MHL0601361	B. WING		C 11/15/2024
SECU YO	ROVIDER OR SUPPLIER  UTH CRISIS CENTER, A I	MONARCH PROGR 1810 BAC	K CREEK DR TE, NC 2821		N. Oro
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	we called him the next suspended him."  Interview and observa approximately 2pm wi PM explained per facil allowed to use their ce working with clients, to present nodded her he -"Cellphones are not a are not suppose to be they are working with a linterview on 10-25-24 -"I was notified on 9-3-informed the PM to sus immediately and I begin on 9-4-24. The international completed on 9-10-24, substantiated and both 9-11-24 for neglect of Interview on 11-4-24 w -"There's always two ounit depending on the at the time. Staff are set themselves in the room client is staff will have a staff will have a staff will have a staff and no on the staff will have a staf	ation on 10-25-24 at th the PM and the DO: lity policy, staff are not ellphones while they are owhich the DO who was ead in agreement. Illowed on the unit. Staff on their cell phones when clients."  with the DO revealed: 24 of the incident. I spend [FS #1] and [FS#2] in the internal investigation was a staff were terminated on FC #1 and FC #2.  with the PM revealed: remore staff working on the number of clients we have uppose to position in so that no matter where a leyes on them"  Hour Reporting  INVESTIGATING AND I CARE PERSONNEL or care facilities to the ations against health care in G.S. 131E-256 (a)(1), known source, shall be	V 110	<ol> <li>V318</li> <li>The Program Manager will in-service training for all numbehavioral technicians on the Critical Incident and Death Reporting Policy, as well as Neglect, and Exploitation.</li> <li>The Director, Program Manand Nurse Manager will conutilize the weekly monitoring ensure safety is maintained</li> <li>The Director, Program Manand Nurse Manager will regreview camera footage to enongoing monitoring, appropostaff interactions, and consist supervision.</li> <li>The Director, Program Manand Nurse Manager will regreview camera footage to enongoing monitoring, appropostaff interactions, and consist supervision.</li> <li>During monthly staff meeting Program Manager will addresleeping policy, cellphone up and Q15 minute safety chemical policy.</li> </ol>	rses and he Ongoing On

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3:		E SURVEY IPLETED
		MHL0601361	B. WING		1	C 1/15/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		1713/2024
SECU Y	OUTH CRISIS CENTER, A	MONARCH PROGR	CK CREEK DE TTE, NC 2821			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 318	This Rule is not met a Based on record revier facility failed to notify the Registry (HCPR) of all 24 hours of learning at 2 of 2 audited staff (FS findings are:  Refer to V 110 regarding review, Video 1-3 regains 8-31-24 FS #1 discovers 8-31-24, the facility's interest of the Department of the Depa	s evidenced by: ws and interviews, the he Healthcare Personnel egations of neglect within bout the allegation affecting is #1 and FS #2 record rding the incident on ered the incident on internal investigation, the it Response Improvement	V 318	DETIVIENC!)		
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Division of Health Service Regulation

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December 16th, 2024

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

RE: Complaint Survey completed November 15, 2024

SECU Youth Crisis Center, A Monarch Program

MHL # 060-1361

Hello,

Enclosed, please find the completed Plan of Correction for deficiencies cited during the survey above.

Please let me know if you have any questions. Thank you.

Sincerely,

Jennifer Smith

**Compliance Specialist** 

Jennifer.Smith@monarchnc.org

ennifer Smith, QP/BA

(704) 322-5058

