

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 09/15/2025
NAME OF PROVIDER OR SUPPLIER SECU YOUTH CRISIS CENTER, A MONARCH P		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	INITIAL COMMENTS A complaint survey was completed on 9/15/25. The complaints were substantiated (Intakes #NC00232286, NC00232288, NC00232442, NC00233109, NC00233110). A deficiency was cited. This facility is licensed for the following service categories: 10A NCAC 27G .3100 non-hospital Medical Detoxification-Individuals who are Substance Abusers. 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups. This facility has a current census of 9. The .3100 non-hospital Medical Detoxification-Individuals who are Substance Abusers has a current census of 0 and the .5000 Facility Based Crisis Service for Individuals of all Disability Groups has a current census of 9. The survey sample consisted of audits of 2 current clients and 2 former clients.	V 000		
V 270	27G .5002 Facility Based Crisis - Staff 10A NCAC 27G .5002 STAFF (a) Each facility shall maintain staff to client ratios that ensure the health and safety of clients served in the facility. (b) Staff with training and experience in the provision of care to the needs of clients shall be present at all times when clients are in the facility. (c) The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual clients. (d) The treatment of each client shall be under the supervision of a physician, and a physician shall be on call on a 24-hour per day basis. (e) Each direct care staff member shall have access at all times to qualified professionals who	V 270		

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

TITLE

(X6) DATE

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V 270	Continued From page 1 are qualified in the disability area(s) of the clients with whom the staff is working. (f) Each direct care staff member shall be trained and have basic knowledge about mental illnesses and psychotropic medications and their side effects; mental retardation and other developmental disabilities and accompanying behaviors; the nature of addiction and recovery and the withdrawal syndrome; and treatment methodologies for adults and children in crisis. (g) Staff supervision shall be provided by a qualified professional as appropriate to the client's needs. This Rule is not met as evidenced by: The facility failed to maintain staff to client ratios that ensure the health and safety of the clients served in the facility. The findings are: Review on 9/5/25 of Client #3's record revealed: - Admission date 8/22/25; - Age 14 years old; - Diagnoses: Adjustment Disorder with Depressed Mood, Disruptive Mood Dysregulation Disorder. Review on 9/5/25 of Client #4's record revealed: - Admission date 8/28/25; - Age 17 years old; - Diagnoses: Major Depressive Disorder, Single Episode Unspecified; Phonological Disorder; Oppositional Defiant Disorder; Autism Spectrum Disorder. Review on 9/5/25 of the North Carolina Incident Response Improvement System from 8/19/25-	V 270		

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V 270	Continued From page 2 9/5/25 revealed: - Date of incident 8/29/25; - Provider Comments- "Per nurse (Licensed Practical Nurse (LPN) #2) on duty, around 8:20pm, BHT (behavioral health technician) staff (Staff #9) discovered the youth (Client #3) in the bathroom with a female peer (Client #4). Both individuals were wearing tops but had no pants on. Staff (Staff #8, Staff #9) promptly separated them to ensure safety and appropriate boundaries. The youth was then directed to their room for processing and support. The supervisor (Program Manager) was notified at 8:36pm, the on-call provider at 8:53pm, and the guardian was informed at 10:00pm." Review on 9/9/25 of the facility's video surveillance on 8/29/25 revealed: - Video titled "DC-15-SECU Side A-Adolescent Day Room time stamped August 29, 2025 7:58:54, 30 minutes 30 seconds; - At 8:01:38 Staff #9 left the day room, Staff #8 sat at a table completing paperwork with 7 clients on the unit; - At 8:04:14 Staff #8 told 5 clients to get away from the shower area and they all walked back over to day room area; - At 8:06:56 Staff #8 noticed two male clients went near the bathroom and told them to not go over to the bathroom if someone was in the bathroom; - At 8:07:00 Staff #8 told the clients "I told y'all I'm by myself, I can't watch y'all if y'all all over there;" - At 8:09:36 Client #4 walked into the bathroom; - At 8:09:57 Client #3 walked into the same bathroom as Client #4; - At 8:10:35 a staff member came and offered the clients a snack and Staff #8 informed the staff member that Client #4 was in the shower at the time;	V 270		

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V 270	Continued From page 3 - At 8:12:54 Staff #8 walked over to the back door and looked outside; - At 8:13:52 Staff #8 sat back down at the table; - At 8:15:22 Staff #9 returned back to the day room and sat at another table across the room from Staff #8; - At 8:17:50 Staff #9 went and stood at the nurses station as the 5 clients gathered near the nurses station; - At 8:18:22 Staff #9 walked into a room beside the bathroom; - At 8:18:46 Staff #9 came back out of the room; - At 8:18:54 Staff #8 walked over to nurses station and told the clients "I'm not in y'all business but come back over here;" - At 8:19:03 Staff #8 was at the nurses station with Staff #9; - At 8:19:16 Staff #8 sat back down at the table; - At 8:23:13 Staff #8 walked over to the bathroom and asked Client #3 if she was alright; - At 8:25:55 Staff #8 walked over to the nurse's station beside Staff #9 then walked to the back door and looked outside, notified the clients that they were unable to go outside due to it being too dark; - At 8:27:19 Staff #8 looked around at all of the clients and immediately put down the container in his hand on the table, walked towards the bathroom, as he approached the bathroom he said something to Staff #9, who then joined Staff #8 walking over to the bathroom; - At 8:27:30 Staff #8 walked into the bathroom; - At 8:27:44 Client #4 walked out of the bathroom and Staff #8 walked out behind him; - At 8:28:02 LPN #2 walked into the bathroom. Review on 9/9/25 of the facility's Investigation dated 9/7/25 revealed: - "Awareness date 8/29/25; - Type of Investigation: Allegation of Abuse,	V 270			

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V 270	Continued From page 4 Neglect, Exploitation; - Additional Conclusions: Video footage shows Behavioral Tech, [Staff #8] with 6 youth on Side A while [Staff #9] the other Behavioral Tech (technician) assigned to the Unit went to assist the nurse (LPN #2) with a new admission. At 7:28pm [Staff #8] can be heard informing the youth (clients) that they cannot split up the group (clients) because he is the only staff on the floor. At 8:15pm [Staff #8] informs the group that the second staff (Staff #9) is back. Video footage confirms that [Staff #8] is the only staff that consistently remains on the floor during that time which is when the incident began. The female youth, [Client #4] enters the bathroom at 8:09:36pm and the male youth, [Client #3] enters the bathroom at 8:09:58pm. They remain in the bathroom together until staff (Staff #9) open the door at 8:27pm. Following the incident the nurse (LPN #2) spoke to both youth (Client #3, Client #4) and [Client #4] was moved to side B. [Doctor] was notified, and [Client #4] was taken to the hospital (allegations of non-consensual sexualized behaviors) on 8/30/25. [Client #3] was seen by a doctor on 9/4/25. Due to staff arriving later than scheduled and another staff (Staff #9) assigned to side A having to assist with an admission the unit was left short staffed, and the prescribed continuous level of observation was not provided to the youth. - Findings: The internal review team met on 9/5/2025 regarding the allegation of neglect against [Staff #8]. The allegation was not substantiated against [Staff #8]. The allegation is substantiated against the facility itself as the facility failed to provide an appropriate level of staffing for the levels of observation." Interview on 9/5/25 with Client #3 revealed: - On 8/29/25 was in the bathroom with Client #4	V 270		

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V 270	Continued From page 5 for 4-5 minutes masturbating with Client #4; - "[Staff #8] was at the table completing paperwork;" - "The other staff (Staff #9) was helping the nurse, and [Staff #8] was by himself." Interview on 9/5/25 with Client #4 revealed: - On 8/29/25 was in the bathroom with Client #3 "against my will;" - "Staff (Staff #8, Staff #9) came in the bathroom and caught him and they made us go into our rooms (bedrooms) and they fussed at us;" - Refused to discussed any other details about the incident of being in the bathroom with Client #3; - Two or three staff worked each shift. Attempted interview on 9/9/25 and 9/11/25 with Staff #8 revealed: - Telephone call to Staff #8, there was no return call before survey exit date. Interview on 9/15/25 with Staff #9 revealed: - Assisted the LPN #2 with an admission on 8/29/25; - Rejoined the milieu and felt things were suspicious due to clients starring me down, trying to see where I was, I picked up on the energy, my surroundings;" - Informed Staff #8 that "something felt off and I felt like they (clients) were plotting something;" - Staff #8 went to the back door and then came back and asked Staff #9 to open the bathroom door; - Saw Client #3 and Client #4 on the floor; - Client #4 was facing Client #3 with no pants on; - Client #3 was on his knees with his shorts around his ankles facing the door; - Notified the clients to put on clothes and leave the bathroom, Client #4 stayed in the bathroom;	V 270		

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V 270	Continued From page 6 - Asked the rest of the clients to go to their bedrooms to make sure the incident didn't escalate any further; - The LPN #2 went into the bathroom and spoke with Client #4; - The LPN #2 checked on Client #3 in his room; - Client #4 was switched to the other unit; - 1st time an incident happened when there was staff shortage; - Staffing ratio depended on the client census. Interview on 9/15/25 with the LPN #2 revealed: - At least two staff worked in each unit; - Staff #9 assisted the LPN #2 for about 30 min-1 hour with a client admission on the evening of 8/29/25; - Was informed by Staff #8 that Client #3 and Client #4 were in the bathroom together on 8/29/25; - Spoke with Client #4 in the bathroom, she reported she had "intercourse" with Client #3 in the bathroom; - Spoke with Client #3 in his bedroom, he reported "masturbating" with Client #4 in the bathroom; Interview on 9/15/25 with the Program Manager revealed: - Staff ratio depended on the client census; - Behavioral tech had a group chat to communicate if they would be late for their shift; - Received a text message from a behavioral tech stating she would be late for shift on 8/29/25; - "We will ask someone to stay over," if a behavioral tech is late to shift; - "Techs should not be leaving shift if all the coverage is not here." Interview on 9/9/25 with the Director of Operations revealed:	V 270			

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V 270	Continued From page 7 - Staff #8 was PRN (as needed) since the investigation on 8/29/25. Review on 9/12/25 of the facility's Plan of Protection dated 9/12/25 and completed by the Director of Operations revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff In-Service Training Notice Beginning September 12th, all staff will participate in mandatory in-service training covering the following topics: A) Proper procedures for notifying leadership when running late or calling out for a scheduled shift B) The expectation that staff remain on duty until officially relieved C) Nurses will be assigned into staffing as needed to maintain appropriate staff-to-patient ratios All training sessions are to be completed by September 19th. - Describe your plans to make sure the above happens. To support successful execution of the in-service training and reinforce the outlined expectations, leadership will take the following steps: Leadership Pop-Ins: Managers will conduct regular pop-ins during shift changes to verify that staff-to-patient ratios are being maintained. Camera Review: Leadership will review camera footage during shift change to ensure staff are arriving on time, staying until properly relieved, and that hand offs are occurring smoothly." The facility served clients with diagnoses of Adjustment Disorder with Depressed Mood, Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Major Depressive Disorder and Autism ranging in age 12-17 years	V 270			

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V 270	Continued From page 8 of age. On 8/29/25, Staff #8 was the only staff on the unit with 7 clients. Client #3 and Client #4 were alone in the bathroom for 17 minutes with different reports of intercourse and masterbation. When Client #4 reported to her grandparent on 8/30/25 that she allegedly was raped, Client #4 she was taken to the hospital and prescribed 2 antibiotics and an emergency contraceptive to prevent pregnancy. Sexually transmitted disease cultures were pending at the time of survey exit. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 270			