Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-204	A. BUILDING: ______ B. WING ______	02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS COTTAGE	**2 COMPTON DRIVE ASHEVILLE, NC 28806**

(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 and limited follow up survey was completed on February 27, 2019. The complaint was unsubstantiated (#NC00148935). This was a limited follow up survey, only 10A NCAC 27G .1901 Scope (314) and 10A NCAC 27G .0205 Assessment and Habilitation, Treatment or Service Plan (V112) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .1901 Scope (314) and 10A NCAC 27G .0205 Assessment and Habilitation, Treatment or Service Plan (V112). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE