

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2019
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NAME OF PROVIDER OR SUPPLIER NEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 5601 FAULCONBRIDGE ROAD CHARLOTTE, NC 28227
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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 limited follow-up and complaint survey was completed on 11/13/19. The complaint was unsubstantiated (Intake #NC 157995). The limited follow-up survey was for a Type B rule violation, only 10A NCAC 27G .1701 Residential Treatment Staff Secure for Adolescents or Children-Scope V293 with cross referenced 10A NCAC 27G .0202 Personal Requirements V108 were reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .1701 Residential Treatment Staff Secure for Adolescents or Children-Scope V293 with cross referenced 10A NCAC 27G .0202 Personal Requirements V108. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Adolescents or Children.</p>	V 000		

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