

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2020
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NAME OF PROVIDER OR SUPPLIER PEACE COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6750 SAINT PETER'S LANE, SUITE 200 MATTHEWS, NC 28105
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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 complaint survey was completed on June 23, 2020. The complaints were unsubstantiated (Intake #NC00165913 and 00165918). No deficiencies were cited.</p> <p>The facility is licesnced for the following service category: 10A NCAC .1900 Psychiatric Residential Treatment Facility for Children and Adolescents.</p>	V 000		

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