

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 03/04/2022
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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>An annual and complaint survey was attempted on 3-4-22. According to the Vice President of Residential Services there are no clients being served at the facility. The last time clients were served at the facility was 2-14-22.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>Interview on 3-4-22 with the Vice President Residential Services revealed: There were no clients currently being served there. He had temporarily closed the facility and didn't expect it to be opened again until possibly May 2022.</p>	V 000		

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