

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601487	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/08/2022
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NAME OF PROVIDER OR SUPPLIER WILLIAMSON COTTAGE-THOMPSON CHILD AND FAM	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 SAINT PETERS LANE 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 limited follow up survey for the Type B was completed on 6-8-22. This was a limited follow up survey, only 10A NCAC 27G .1804 Minimum Staffing Requirements (V304) and 10A NCAC 27G .1801 Scope (V301) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .1804 Minimum Staffing Requirements (V304) and 10A NCAC 27G .1801 Scope (V301). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 1800 Intensive Residential Treatment for Children or Adolescents.</p> <p>This facility is licensed for nine and currently has a census of seven. The survey sample consisted of three current clients.</p>	V 000		

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