

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601172	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2022
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NAME OF PROVIDER OR SUPPLIER ALPHIN COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6750 SAINT PETERS LANE, SUITE 400 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 was attempted on October 12, 2022. According to the Chief Performance and Quality Officer there are no clients being served at the facility. The last time clients were served at the facility was April 20, 2022.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Treatment for Children and Adolescents.</p> <p>Interview on October 9, 2022 with the Chief Performance and Quality Officer revealed: -No clients currently at the facility; -Last client served was on April 20, 2022; -Hope to admit clients to the facility during November, 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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