STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601227	A. BUILDING: _____ B. WING _____	01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERANCAS COTTAGE	6750 SAINT PETERS LANE, SUITE 300 MATTHEWS, NC 28105

(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	INITIAL COMMENTS An annual, follow up and complaint survey was attempted on 1-23-23. According to the Quality Assurance Director, there are no clients being served at the facility. The last time clients were served at the facility was 12-8-23. This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Facility for Children or Adolescents This facility is licensed for six and currently has a census of zero. The survey sample consisted of one former client. Interview on 1-23-23 with the Quality Assurance Director revealed: -The last time clients had been served at the facility was 12-8-23. That client had been transferred to another facility on campus.	V 000		