

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2023
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NAME OF PROVIDER OR SUPPLIER LORETTA'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 109 PENNY STREET ALBEMARLE, NC 28001
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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 March 23, 2023. The complaints were unsubstantiated (Intake #NC00199440 and #NC00199686). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 1900 PRTF- Psychiatric Residential Treatment Facility for children and adolescents.</p> <p>This facility is licensed for twelve and currently has a census of nine. The survey sample consisted of audits of two current clients and 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____