STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601172	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHIN COTTAGE	6750 SAINT PETERS LANE, SUITE 400 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 A complaint survey was completed on 4-6-23. Two complaints were substaniated (#NC00199740 and #NC00199666, and one complaint was unsubstantiated (#NC00198224). No deficiencies were cited. This facility is licensed for the following service category: Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for six and currently has a census of five. The survey sample consisted of audits of two current clients.	V 000		