Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL090-217 | A. BUILDING: _____ B. WING _____ | R 05/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JAMES COTTAGE | 1915 HASTY ROAD, SUITE F MARSHVILLE, NC 28103 |

| (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<br><br>A limited follow up survey for the Type A1 was completed on 5-11-23. This was a limited follow up survey, only 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512). No deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 2567 G 1300 Residential Treatment for Children or Adolescents. | V 000 | | |

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