PRINTED: 06/27/2023 FORM APPROVED

Division of Health Service Regulation

EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
RRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
	MHL090-218	B. WING		R 06/22	2/2023
ER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	1915 HAST	Y ROAD, SUIT	E D		
AGE	MARSHVIL	LE, NC 28103			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
0 INITIAL COMMENTS		V 000			
6-22-23. The comp	plaint was unsubstantiated				
This facility is licensed for the following service category: 10A NCAC 27G 1300 Residential Treatment for Children and Adolescents.					
a census on seve	en. The survey sample				
3 .0604 Incident R	eporting Requirements	V 367			
PORTING REQUIL TEGORY A AND B Category A and B el II incidents, exce provision of billab sumer is on the product of the provider days prior to the in ponsible for the ca vices are provided coming aware of the submitted on a for cretary. The report erson, facsimile of ans. The report sh remation: reporting pro ntification informat client identif type of incidentification.	REMENTS FOR PROVIDERS Providers shall report all pet deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within ricident to the LME tchment area where within 72 hours of le incident. The report shall m provided by the t may be submitted via mail, r encrypted electronic hall include the following lovider contact and lion; fication information; lent;				
	SUMMARY STI (EACH DEFICIENCY REGULATORY OR LE TIAL COMMENTS Complaint and follow 6-22-23. The complaint is licensed as facility is licensed as census on several sisted of audits of the relief of audits of the relient. S. 0604 Incident R NCAC 27G .0604 PORTING REQUILIFEGORY A AND B Category A and B BILL Incidents, excellations of billable sumer is on the provision of billable sumer is on the provider days prior to the inconsible for the capitoes are provided only aware of the capitoes are provided on a formation of the report in the repor	MHL090-218 ER OR SUPPLIER AGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FIAL COMMENTS Omplaint and follow up survey was completed 63-22-23. The complaint was unsubstantiated CO0202364). Deficiencies were cited. Is facility is licensed for the following service agory: 10A NCAC 27G 1300 Residential atment for Children and Adolescents. If acility is licensed for twelve and currently a census on seven. The survey sample sisted of audits of two current clients and one ner client. INCAC 27G .0604 INCIDENT PORTING REQUIREMENTS FOR TEGORY A AND B PROVIDERS Category A and B providers shall report all all incidents, except deaths, that occur during provision of billable services or while the sumer is on the provider premises or level III dents and level II deaths involving the clients whom the provider rendered any service within days prior to the incident to the LME consible for the catchment area where vices are provided within 72 hours of oming aware of the incident. The report shall submitted on a form provided by the cretary. The report may be submitted via mail, erson, facsimile or encrypted electronic ans. The report shall include the following	RECTION IDENTIFICATION NUMBER: MHL090-218 ER OR SUPPLIER AGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAL COMMENTS Omplaint and follow up survey was completed 3-22-23. The complaint was unsubstantiated C00202364). Deficiencies were cited. Safacility is licensed for the following service eggry: 10A NCAC 27G 1300 Residential atment for Children and Adolescents. Facility is licensed for twelve and currently a census on seven. The survey sample sisted of audits of two current clients and one ner client. S. 0604 Incident Reporting Requirements NCAC 27G .0604 INCIDENT PORTING REQUIREMENTS FOR REGORY A AND B PROVIDERS Category A and B providers shall report all all incidents, except deaths, that occur during provision of billable services or while the sumer is on the provider premises or level III dents and level II deaths involving the clients whom the provider rendered any service within days prior to the incident to the LME consible for the catchment area where vices are provided within 72 hours of oming aware of the incident. The report shall submitted on a form provided by the cretary. The report may be submitted via mail, erson, facsimile or encrypted electronic ans. The report shall include the following reporting provider contact and nutification information; client identification information; type of incident; description of incident; description of incident; description of incident;	RECTION DENTIFICATION NUMBER: A BUILDING:	RECTION DENTIFICATION NUMBER: A BUILDING: COMPLE R 06/22 BY WIND BUILDING: COMPLE COMPLE COMPLE COMPLE COMPLE BY WIND BUILDING: COMPLE COMPLE COMPLE COMPLE BY WIND BUILDING: COMPLE COMPLE COMPLE COMPLE BY WIND BUILDING: COMPLE COMPLE BY WIND BUILDING: COMPLE COMPLE BY WIND COMPLE COMPLE

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

PRINTED: 06/27/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	,
		MHL090-218	B. WING		1	22/2023
NAME OF PROVIDER OR SUP	PLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LENDON COTTAGE		1915 HAS	TY ROAD, SUIT	TE D		
LENDON COTTAGE		MARSHV	LLE, NC 28103	3		
PREFIX (EACH [DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367 Continued Fr	om page	e 1	V 367			
cause of the (6) oth or responding (b) Category missing or inshall submit a report recipied day whenever (1) the information perroneous, mr (2) the required on the unavailable. (c) Category upon request obtained regal (1) hos information; (2) rep (3) the (d) Category of all level III Mental Health Substance Albecoming away providers shall incidents involved the period of the common away client death wor restraint, the immediately, .0300 and 10 (e) Category report quarte catchment ar The report shall substance and the common away client death wor restraint, the immediately, .0300 and 10 (e) Category report quarte catchment ar The report shall repor	incident; er individent; er individent; er individent; er an update ents by the er: provided his leading provided he incident he incident er A and Be to by the Larding the provident er A and Be incident h, Development er A end Be incident h, Development er A end Be incident h, Development er A end Be incident er and		V 36/			

Division of Health Service Regulation

STATE FORM 6899 0UWZ11 If continuation sheet 2 of 4

Division of Health Service Regulation

	or rieditir Service Negu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		A. BUILDING:		COMPLETED	
					_D
		MUU 000 040	B WING		R
		MHL090-218	B. W. C		06/22/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		1915 HAS	TY ROAD, SUIT	TE D	
LENDON	COTTAGE		LLE, NC 28103		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 367	Continued From page	2	V 367		
	include summary info	rmation as follows:			
		errors that do not meet the			
	definition of a level II				
		nterventions that do not meet			
	1 ' '				
		el II or level III incident;			
		a client or his living area;			
		client property or property in			
	the possession of a c				
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	mber of level II and level III			
	incidents that occurre				
	, ,	indicating that there have			
	been no reportable in				
		ed during the quarter that			
	_	ia as set forth in Paragraphs			
		e and Subparagraphs (1)			
	through (4) of this Par	ragraph.			
	This Rule is not met as evidenced by:				
	Based on record revie	ew and interviews, the			
	facility failed to ensure	e incidents were reported to			
		nt Entity/Managed Care			
		CO) for the catchment area			
		rovided within 72 hours of			
	becoming aware of the incident. The findings				
	are:	go			
	G. 5.				
	Review on 5-18-23 of	the facility incident reports			
	Review on 5-18-23 of the facility incident reports revealed:				
		I from the facility 5 16 22			
	-Gliefit # Feloped	I from the facility 5-16-23.			
	Review on 5-18-23 of	Incident Response			

Division of Health Service Regulation

Improvement System (IRIS) revealed:

STATE FORM 6899 0UWZ11 If continuation sheet 3 of 4

PRINTED: 06/27/2023 FORM APPROVED

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						R	
		MHL090-218	B. WING		II	22/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LENDON	LENDON COTTAGE 1915 HASTY ROAD, SUITE D MARSHVILLE, NC 28103						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 367	-No report had be system until 5-22-23. Interview on 5-18-23 Director revealed: -She had recently ensure that all incider sure they were entered.	with the Quality Assurance y put a system in place to ats were checked to make ad in a timely manner. sents a recited deficiency	V 367				

Division of Health Service Regulation

STATE FORM 6899 0UWZ11 If continuation sheet 4 of 4