Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					c	
		MHL090-217	B. WING		06/21	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
JAMES C	TTAGE	1915 HAST	TY ROAD, SUIT	EF		
JANESC	JIIAGE	MARSHVIL	LE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	000 INITIAL COMMENTS		V 000			
	Two complaints were NC00216491 and #N complaints were unsu #NC00217170 and #I were cited. This facility is license category: 10A NCAC Treatment For Childre This facility is license census of 5. The sur	d for the following service 27G .1300 Residential en Or Adolescents. d for 12 and currently has a vey sample consisted of				
	audits of 1 current clie	ent.				
V 112	PLAN (c) The plan shall be assessment, and in plegally responsible per of admission for clien receive services beyond the plan shall incomplete the plan shall incomposed the projected date of ach (2) strategies; (3) staff responsible (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude: I that are anticipated to be a of the service and a lievement; I view of the plan at least on with the client or legally r both; I to the service and a lievement of	V 112			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:			COMPLETED
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		MHL090-217	B. WING		06/21/2024
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STA	TE ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER				
JAMES C	OTTAGE		STY ROAD, SUIT /ILLE, NC 28103		
	CLIMMA DV CT				NI
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 112	Continued From page	: 1	V 112		
	provider stating why sobtained.	such consent could not be			
	facility failed impleme	ews and interviews, the ent goals and strategies to eeds of 1 of 1 audited clients			
	-Date of admission: 1 -Age: 11Diagnoses: Post Tra Persistent Depression DisorderPerson Centered Pla updated 3-22-24 inclustrategies: -"[Client #1] will impropracticing coping skill restrictive intervention -"HOW (Support/Interparticipate in skill buil individual and group to treatment recommence times." -"Level II will provide group-based activities therapy as identified."	umatic Stress Disorder; n; Generalized Anxiety In dated 10-17-23 and Ided the following goal and Ive mood regulation by s 2-3x daily. Approved for n." Ivention): Client will: Engage ding groups, as well as herapy. Comply with dations and safety plan at all Icommunity-based activities, s, and individual/family/group			
	-"Therapist will provid	e cognitive behavioral r therapist specific modality			

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Division	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL090-217	B. WING		1	21/2024
		WITILU90-217			06/2	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
141450.0	OTT4 OF	1915 HAS	STY ROAD, SUIT	E F		
JAMES C	DITAGE	MARSHV	ILLE, NC 28103	•		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
V 112	Continued From page	e 2	V 112			
	to assist client with sy	ymptom management and				
		oving (whatever the focus of				
	that particular goal is	- '				
		d in goal) are reduced.				
		inger management skills,				
	appropriate communi					
		p and think skills. Therapist				
	_	erapy as necessary and				
	provide parent trainin					
		f therapy for client #1 from				
	2-6-24 to 5-7-24.	r anorapy for enome # 1 from				
	2021100721.					
	Interview on 5-10-24	and 6-14-24 with Client #1				
	revealed:					
	-"Yes" he is receiving	therapy. "Umm, I'm not				
	sure (how often he is	getting his therapy.)"				
	-Not sure how long he	e went without receiving				
	therapy.					
	-"She (former therapi	st) left."				
	-He (client #1) was of	ffered teletherapy.				
	-"I don't know (why he	e refused teletherapy), I				
	didn't want to (particip	pate with teletherapy)."				
	Interview on 5-10-24 Quality Improvement	and 5-29-24 with the Chief				
	, ,					
		left unexpectedly (resigned bruary 2024 (2-15-24).				
		was a period where he				
	(client #1) did not get					
		ient #1) therapy through an				
	alternative therapist b					
	alternative therapist t	out he refused.				
	Attempted interview of	on 5-10-24 with the former				
		nsuccessful. FT did not				
	answer her phone an					
	-	at the time of the contact.				
	, 5					
	Review on 5-29-24 of	f an email from the Chief				
	Quality Improvement	Officer, sent to the Division				
	of Health Service Reg	gulations revealed: "Lastly, I				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MUU 000 047	B. WING		C	
		MHL090-217		TE 710 000E	06/21/2024	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA Y ROAD, SUIT			
JAMES COTTAGE			LE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
V 112	Continued From page	÷ 3	V 112			
	as well as all other cli teletherapy within the was down a therapist					
	Interview on 5-28-24 with the Chief Agency Officer on 5-10-24, 5-28-24 and 6-20-24 revealed: -"[Client #1] was offered therapy with [teletherapy provider], but he refused. I asked him (client #1) twice and he said no both times After he refused the second time I did not want to keep asking him and risk agitating him." -"We talked to his guardian, she was aware of the therapist (FT) leaving. She (guardian) signed the consent for him to receive the therapy, but he did not want to do it over the computer. He does not like the computer." -"We (staff) had the computer on, screen up, ready for the session (therapy session) but he would not participate, The second time, the same thing (client #1 refused to participate in teletherapy). I think he was playing with his [electronic game] and he wouldn't put it down to do his therapy. He was getting angry when we asked him to do the therapy."					
	revealed:	with client #1's Guardian client #1 did not receive o 5-7-24.				
V 179	27G .1301 Residentia	al Tx - Scope	V 179			
	10A NCAC 27G .130′ (a) The rules of this S residential treatment residential treatment, service.	Section apply only to a facility that provides				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL090-217	B. WING		06/2 ²	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE		
			STY ROAD, SUITI			
JAMES CO	OTTAGE	MARSH\	/ILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 179	residential treatment, licensed as set forth i (c) A residential treat adolescents is a free-which provides a stru within a system of car adolescents who have mental illness or emormay also have other (d) Services shall be functioning level of the include training in self skills, social skills, an Children or adolescent day treatment facility, attend school. (e) Services shall be child or adolescent in to return to the natural setting. (f) The residential treatment facility at the school.	level III service, shall be in 10A NCAC 27G .1700. Iment facility for children and standing residential facility ctured living environment approach for children or e a primary diagnosis of tional disturbance and who disabilities. I designed to address the e child or adolescent and f-control, communication directed receive services in a have a job placement, or designed to support the gaining the skills necessary all, or therapeutic home	V 179			
	facility failed to coord individuals and agend	ew and interviews, the inate care with other cies within the client's ing 1 of 1 audited clients				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MIII 000 047	B. WING		C
MHL090-217		MHL090-217	B. WING		06/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
JAMES C	OTTAGE	1915 HAS	TY ROAD, SUIT	ΈF	
OAIIIEO O		MARSHV	LLE, NC 28103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 179	Continued From page	e 5	V 179		
	-Date of admission: 1 -Age: 11Diagnoses: Post Tra Persistent Depression DisorderPerson Centered Pla updated 3-22-24: "C school on daily basis Review on 5-21-24 of attendance record for through 5-1-24 revea -Out of 78 school day in after the 7:30am be -Out of 78 school day	umatic Stress Disorder; n; Generalized Anxiety an dated 10-17-23 and lient will: Attend public ." f client #1's school r the period of 11-1-23 led: /s, client #1 was late (signed			
	Worker (SSW) reveal -"Communication has When we (school sta (facility staff) we coul phone. Most of the ti ring and no one woul voicemail we would le would call back." -"We have (school sta (dates and number of (with facility staff) but answered." -"He (client #1) was of leaving early. They (of unidentified clients) we mornings fighting or hand being loud and do not being returned.	s been an ongoing issue. Iff) tried to reach out to them d never get anyone on the me the phone would just d pick up or if it went to eave messages but no one Iff) made several requests f request unknow) to meet of those requests were not If the phone would just to meet the			

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the home to help them keep up with their

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction.	IDENTIFICATION NOMBER.	A. BUILDING:		OOM! LETED	
					С	
		MHL090-217	B. WING		06/21/2024	4
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
141450 0	2774.05	1915 HAS	STY ROAD, SUITE	F		
JAMES CO	JAMES COTTAGE MARS					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X	X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMP	PLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DA	ATE
V 179	Continued From page	e 6	V 179			
	homework, papers ar	nd things. He would go home				
	with it, but not bring it					
		with client #1 revealed:				
		l go to school every day."				
	-"I'm never late."					
	-	n the van to school or at				
	school.					
	•	f any clients fighting on the				
	van or at school.	and II				
	-"I don't have homew	ork.				
	Interview on 5-10-24	with the facility Case				
	Manager (CM) reveal	-				
		M with the facility since				
	March 2024 (3-18-24					
		s (clients) that are here (at				
	the facility), manage (all school related iss	.treatments plans, school				
	•	ion to school enrollment				
		o 10 days at the most.				
		t communication (with the				
		issue in the past. I have				
	made contact with ea	·				
	introduce myself and	establish that point of				
	_	(school personnel) my				
	direct number so that	they can contact me directly				
		rough the main number				
	(facility number), and	•				
		ng about every two weeks				
		ontact and to discuss ideas				
	or issues."					
	-"We are really trying					
	`	hool personnel when a				
		bsent). The supervisor on				
	day shift will send an	email to the school letting				

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them (child's teacher) know the child is not coming to school or is going to be late due to whatever reason. Then I put a note in the child's (client's) chart about why the child is not coming

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		MHL090-217	B. WING		06/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1915 HAS	TY ROAD, SUIT	TE F	
JAMES C	OTTAGE		LLE, NC 28103		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ON (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 179	Continued From page	e 7	V 179		
	to achool today "				
	to school today."	homework, then the staff in			
	- , , ,	onsible for assisting that			
		ork. First shift staff usually			
	does the transport an	•			
	homework gets back				
		een some instance (clients'			
		school). We (staff) had			
	some kids (clients) th				
	, ,	to school, some behaviors			
	_	ve needed to be addressed			
	before they (clients) v				
	Interview on 6-14-24	with the former Case			
	Manager revealed:				
		5-2-23) as Case Manager.			
		ween [the facility] and the			
		aling with the school process			
		ssions, treatment plans, all			
	of that, was my job."	. ,			
		y communication issues			
		I until he stepped out of the			
	position.	alls, emails when I got them.			
		pril (2024) there were some			
	l	cation. I think due to all the			
		sition), and also it was the			
		and of the year testing was			
	going on. I think the				
		t #1 was being dropped off			
		rotocol is if a client is going			
		would call or send an email			
	to the teacher informi	ng her that [client #1] would			
		e for whatever reason. No			
	,	communicated to me that			
	[client #1] was coming				
	-"I actually reached o	•			
		2024) regarding [client #1]			
		noticed he was not bringing			
	homework home like	he use to and I suspected it			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			, DOILDING		C	
		MHL090-217	B. WING		06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
JAMES CO	OTTAGE		STY ROAD, SUIT	EF		
			ILLE, NC 28103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 179	Continued From page	e 8	V 179			
	may have been disape (the facility). So I real they assigned [client: #1's homework) to make a completed and substitution of the facility of the facility. The facility of the facility of the facility of the facility of the facility. So I read they assigned for the facility of the facil	pearing on the way here ched out and and asked if #1] homework email it (client e and I would make sure it ent back to school." Cher), emailed his (client e a few times, but then I I assumed he was not ck." and 6-20-24 with the Chief led: communication issues facility and the various lementary, middle and high eabout the issues (unknown carted working on how can calling meetings with all of he can get to know us and we not we do and so that we can ow to best serve the kids." ager, she has already out some things in place that				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	manner and shall be odor. This Rule is not met Based on observation	EMENTS as grounds shall be clean, attractive and orderly kept free from offensive as evidenced by: and interviews the facility a safe, clean, attractive				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					C	
		MHL090-217	B. WING		06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
	1915 HAS			'E F		
JAMES C	OTTAGE		LLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	9	V 736			
	1:30pm and 2pm reversibility of the door way. An area applong where the wall high painted. Bedroom #1's bathroom inssing the the roller roller in place. The pcompletely torn from approximately 12 to 1 inches wide where the drywall was exposed. bathroom door had a wide. The bathroom approximately black malengths from a black malengths from a black board. Bedroom #3 had a vette source could not be coming into bedroom scribbling from a black black malengths from a black malengths from a black b	a, a brown leather chair had ther on the cushion of the the chair approximately 12 ches wide where the dry ad but not painted. with food debris. adding into bedroom #3 was ad running the length of approximately 8 to 10 inches ad been repaired but not to be approximately 8 to 10 inches and the arm that held the apper towel dispenser was the wall, leaving an area 8 inches long and 6 to 8 to 8 to 9 approximately 2 inches door had numerous gauge marks that appeared to the state of the				

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the bedroom was

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL090-217	B. WING		06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
JAMES C	OTTAGE		TY ROAD, SUIT			
		MARSHV	ILLE, NC 28103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 736	Continued From page 10		V 736			
	above the toilet. Ther from the pillow to app the bed. Bedroom #5's . Bedro feces that could not locrumbs in the bed, a were stained and soil had an approximately shape painted on the right of the red X were minces in length pain sink and the faucet are stained with black pain missing and the paper missing. The electrica mirror above the sink black. Bedroom #6 was uno renovated.	· ·				
	Interview on 5-10-24 with Client #1 revealed: -He cleaned his own room. "I make up my bed myself. Sometimes the staff help. It's clean (cottage) I like it."					
	-"I like it (living at the	with Client #3 revealed: facility), it's ok." s and staff) clean it up				
	Interview on 5-10-24 -The facility is cleane	with Client #4 revealed: d everyday.				
	Improvement Officer	with the Chief Quality Revealed: ake up their beds and				

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go to school."

straighten their rooms every morning before they

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING: COMPLETED		SURVEY PLETED		
			B. WING		I	С
		MHL090-217			06	/21/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATI ASTY ROAD, SUITE			
JAMES C	OTTAGE		VILLE, NC 28103	- '		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	-The staff are response cottage is clean. Interview on 6-20-24 Officer revealed: -"We have been work them understand that the cottages are clean.	with the Chief Agency sing with the staff to make tit is their job to make sure ned. We are in the process tems to make sure this	V 736			

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