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 03/14/2025

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 An annual, complaint and follow up survey was completed on March 14, 2025. One complaint was substantiated (intake #NC00223032) and one complaint was unsubstantiated (intake #NC00228129). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment For Children Or Adolescents. This facility is licensed for 12 and currently has a census of 8. The survey sample consisted of audits of 3 current client.	V 000		