

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-217</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/20/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JAMES COTTAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915 HASTY ROAD, SUITE F</b> <b>MARSHVILLE, NC 28103</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 5-20-25. The Complaints were unsubstantiated (#NC00228725 and #NC00228574. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p> <p>This facility is licensed for 12 and currently has a census of 7. The survey sample consisted of audits of 3 current clients.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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