Division of Health Service Regulation

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING:  B. WING  NAME OF PROVIDER OR SUPPLIER  YORKE COTTAGE  STREET ADDRESS, CITY, STATE, ZIP CODE  6750 SAINT PETERS LANE, SUITE 100  MATTHEWS, NC 28105	_ COMPLETED _ 06/23/2025
NAME OF PROVIDER OR SUPPLIER  YORKE COTTAGE  STREET ADDRESS, CITY, STATE, ZIP CODE  6750 SAINT PETERS LANE, SUITE 100  MATTHEWS, NC 28105	06/23/2025
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V 000 INITIAL COMMENTS V 000	
A complaint and follow up survey was completed on 6-23-25. The complaint was substantiated (#NC00230696). Deficiencies were cited.	
This facility is licensed for the following category: 10A NCAC 27G Psychiatric Residential Treatment for Children and Adolescents.	
This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	
V 536 27E .0107 Client Rights - Training on Alt to Rest. V 536 Int.	
10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS  (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.  (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.  (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.  (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable	

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  MHL0801171  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1759 SAINT PETERS LANE, SUITE 100  MATTHEWS, NC 28198  (A) PROVIDERS PLAN OF CORRECTION  (A) ID PRESENT  SUMMARY STATEMENT OF DEFICIENCIES  (B) SUMMARY STATEMENT OF DEFICIENCIES  (C) SUMMARY STATEMENT OF DEFICIENCIES  (B) SUMMARY STATEMENT OF DEFICIENCIES  (C) Formal refresher training must be completed by each service provider periodically (minimum annually).  (C) Content of the training that the service provider wishes to employ must be approved by the Division of MHLDOSAS pursuant to Paragraph (g) of this Rule.  (g) Staff shall demonstrate competence in the following core areas:  (1) Knowledge and understanding of the people being served;  (2) recognizing an interpreting human behavior;  (3) recognizing the effect of internal and external stressors that may affect people with disabilities;  (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;  (7) sallis in assessing individual risk for escalating behavior;  (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and  (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe),  (h) Service providers shall maintain documentation of initial and refresher training for at least three years.  (1) Documentation shall include:	DIVISION	n nealth Service Negu	lation				
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assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		·					
decisions about their life;  (7) skills in assessing individual risk for escalating behavior;  (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and  (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).  (h) Service providers shall maintain documentation of initial and refresher training for at least three years.							
(7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		-	_				
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(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		(7) skills in ass	essing individual risk for				
and de-escalating potentially dangerous behavior; and  (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).  (h) Service providers shall maintain documentation of initial and refresher training for at least three years.							
and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		(8) communica	tion strategies for defusing				
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).  (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		and de-escalating pot	tentially dangerous behavior;				
means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		and					
means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.		(9) positive beh	navioral supports (providing				
activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.							
behaviors which are unsafe).  (h) Service providers shall maintain documentation of initial and refresher training for at least three years.							
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.							
documentation of initial and refresher training for at least three years.			,				
at least three years.							
			a. aa reneene. danning for				
(1) Dournation chair morage.		· ·	tion shall include:				
(A) who participated in the training and the		\ <i>\</i>					

Division of Health Service Regulation

STATE FORM 6899 ICLD11 If continuation sheet 2 of 10

Division of Health Service Regulation

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601171	B. WING	B. WING		3/2025
NAME OF PROV	IDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
YORKE COTT	<b>TAGE</b>	6750 SAI	NT PETERS LAN	NE, SUITE 100		
		MATTHE	WS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536 C	ontinued From page	2	V 536			
ot (B) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C	utcomes (pass/fail);  by when and way instructor's  The Division view/request this do Instructor Qualificate equirements:  Trainers shay scoring 100% on to med at preventing, it is east for restrictive interestrictive interestrictive interestrictive interestrictive interestrictive interestrictive interestrictive, measurable passing is structor training properties, measurable methods illing the course.  The content ervice provider plans opervation of behavious easurable methods illing the course.  The content ervice provider plans opervation of behavious easurable methods in a content of the course.  The content ervice provider plans opervation of behavious easurable methods in the course.  The content of the content of the course is a content of the course in th	where they attended; and name; no fMH/DD/SAS may ocumentation at any time. ations and Training all demonstrate competence esting in a training program reducing and eliminating the erventions. all demonstrate competence grade on testing in an angram. shall be include measurable learning the testing (written and by or) on those objectives and to determine passing or of the instructor training the sto employ shall be ion of MH/DD/SAS pursuant				

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STATE FORM 6899 ICLD11 If continuation sheet 3 of 10

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	TION NUMBER:  A. BUILDING:		COMPLETED	
		MHL0601171	B. WING		06/23/202	5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
YORKE C	OTTAGE	6750 SAIN	T PETERS LAN	NE, SUITE 100		
TORRE	OTTAGE	MATTHEW	S, NC 28105			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	(X5) IPLETE IATE
V 536	Continued From page	e 3	V 536			
	need for restrictive infannually.  (8) Trainers shainstructor training at le (j) Service providers documentation of inititraining for at least the (1) Docume (A) who participoutcomes (pass/fail);  (B) when and verification (C) instructor's (2) The Division request and review the (k) Qualifications of (1) Coaches share (2) Coaches share course which is be (3) Coaches share course which is be (3) Coaches share trainer instruction (I) Documentation share for trainers.	all complete a refresher east every two years. shall maintain fall and refresher instructor ree years. entation shall include: eated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation iner. In all teach at least three times eing coached. In all demonstrate oletion of coaching or latel the same preparation hall be the same preparation.				
	staff (Former Staff #1	e that 1 of 1 audited former ) completed semi-annual s to restrictive interventions.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL0601171	B. WING		06/23/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	O-T-1 O-	6750 SAIN	T PETERS LAN	NE, SUITE 100	
YORKE C	OTTAGE	MATTHEW	S, NC 28105		
(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 536	Continued From page	e 4	V 536		
	Review on 6-10-25 of Former Staff #1 (FS#1)'s record revealed:  -Hire date 10-9-23, termination date 5-16-25Therapeutic Crisis Intervention (TCI) training last completed on 10-13-23.  Interview on 6-19-25 with FS#1 revealed: -She remembers she had TCI training "sometime last year."  Interview on 6-18-25 with the facility supervisor revealed: -FS#1's training was probably overlooked because FS#1 was regularly in the hospitalFS#1 had been in the hospital several times in the last yearThey would make sure to monitor the trainings more closely in the future so training for all staff would be up to date.				
V 537	170  10A NCAC 27E .0108 SECLUSION, PHYSI ISOLATION TIME-OL (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to em procedures are retrain competence at least a (b) Prior to providing disabilities whose trea includes restrictive int service providers, em	CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that apploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including	V 537		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		MHL0601171	B. WING		06/23/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
VODKE O	0774.05	6750 SAIN	IT PETERS LAN	NE, SUITE 100	
YORKE C	OTTAGE	MATTHEV	VS, NC 28105		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 537	Continued From page	e 5	V 537		
V 537	seclusion, physical reand shall not use the training is completed demonstrated.  (c) A pre-requisite for demonstrating competeratining in preventing the need for restrictive (d) The training shall include measurable lead measurable testing (where the testing of the training shall include measurable testing (where the testing of the testing of the training testing to the training testing the Division of MH/DI provider plans to empted the United to, (1) refresher in the use of restrictive in (2) guidelines of (2) guidelines of (3) emphasis of the manufacture of the training the strictive in the use of restrictive in (2) guidelines of (3) emphasis of the manufacture of the training the strictive in (3) emphasis of the manufacture of the training the strictive in (3) emphasis of the manufacture of the training the manufacture of the manufactur	estraint and isolation time-out se interventions until the and competence is  r taking this training is stence by completion of reducing and eliminating e interventions.  be competency-based, earning objectives, written and by observation of ojectives and measurable e passing or failing the  training must be completed der periodically (minimum ning that the service oloy must be approved by D/SAS pursuant to Rule.  ng programs shall include, presentation of: formation on alternatives to	V 537		
	concepts of least restrictive interventions and incremental steps in an intervention);  (4) strategies for the safe implementation				
	interventions which in assessment and mon	mergency safety			
		ghout the duration of the			

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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	
		MHL0601171	B. WING		06	6/23/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	•	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		6750 SAI	NT PETERS LAN	E, SUITE 100		
YORKE C	OTTAGE	MATTHE	WS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	(7) debriefing simportance and purp (8) documentation of init at least three years. (1) Documentation (A) who particip outcomes (pass/fail); (B) when and (C) instructor's (2) The Division review/request this did (i) Instructor Qualific Requirements: (1) Trainers ship y scoring 100% on aimed at preventing, need for restrictive in (2) Trainers ship y scoring 100% on teaching the use of sand isolation time-out (3) Trainers ship y scoring a passing instructor training professional documents and isolation training professional contents and purpose important contents and purpose i	or; brocedures; strategies, including their lose; and lition methods/procedures. It is shall maintain litial and refresher training for lation shall include: bated in the training and the lition shall include; bated in the training and the lition shall include; bated in the training and the lition of MH/DD/SAS may ocumentation at any time. It is lated to a training lition and Training lition and Training lition and Training program reducing and eliminating the laterventions. It is lated the lition and training program reclusion, physical restraint lition and the laterventions in a training program reclusion, physical restraint lition and the latervention and lition and liti	V 537			
	competency-based, objectives, measural observation of behave measurable methods failing the course.  (5) The conterservice provider planapproved by the Divi	include measurable learning ble testing (written and by vior) on those objectives and is to determine passing or at of the instructor training the is to employ shall be sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6)	o) Of this Rule.				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				_	
		MHL0601171	B. WING		06/23/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6750 SAIN	IT PETERS LAN	NE, SUITE 100	
YORKE C	OTTAGE	MATTHEV	VS, NC 28105		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 7	V 537		
V 537	shall include, but not of:  (A) understandi (B) methods for course;  (C) evaluation of (D) documentat (7) Trainers share annually and demonst of seclusion, physical time-out, as specified Rule.  (8) Trainers share CPR.  (9) Trainers share coach.  (10) Trainers share coach.  (10) Trainers share coach.  (10) Trainers share coach.  (11) Trainers share coach.  (12) Trainers share coach.  (13) Trainers share coach.  (14) Trainers share coach.  (15) Trainers share coach.  (16) Trainers share coach.  (17) Trainers share coach.  (18) Trainers share coach.  (19) Trainers share coach.  (10) Trainers share coach.  (11) Trainers share coach.  (12) Trainers share coach.  (13) Trainers share coach.  (14) Trainers share coach.  (15) Trainers share coach.  (16) Trainers share coach.  (17) Trainers share coach.  (18) Trainers share coach.  (19) Trainers share coach.  (10) Trainers share coach.  (10) Trainers share coach.  (11) Trainers share coach.  (12) Trainers share coach.  (13) Trainers share coach.  (14) Trainers share coach.  (15) Trainers share coach.  (16) Trainers share coach.  (17) Trainers share coach.  (18) Trainers share coach.  (19) Trainers share coach.  (19) Trainers share coach.  (10) Trainers share coach.  (11) Trainers share coach.  (12) Trainers share coach.  (13) Trainers share coach.  (14) Trainers share coach.  (15) Trainers share coach.	be limited to, presentation  ng the adult learner; r teaching content of the  of trainee performance; and cion procedures. all be retrained at least ctrate competence in the use I restraint and isolation I in Paragraph (a) of this  all be currently trained in  all have coached experience f restrictive interventions at a positive review by the  all teach a program on the rventions at least once  all complete a refresher east every two years. c shall maintain ial and refresher instructor	V 537		
	outcome (pass/fail);	-			
		vhere they attended; and			
	(C) instructor's				
	(2) The Division of MH/DD/SAS may				
		ocumentation at any time.			
	(I) Qualifications of C				
	· ·	nall meet all preparation			
	requirements as a tra				
	` '	nall teach at least three			
	times, the course whi (3) Coaches sh	ch is being coached. nall demonstrate			

Division of Health Service Regulation

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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	ILED
		MHL0601171	B. WING		06/23	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
YORKE C	OTTAGE	6750 SAIN	T PETERS LAN	NE, SUITE 100		
TORKE C	OTTAGE	MATTHEW	S, NC 28105			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 537	Continued From page competence by comp train-the-trainer instru (m) Documentation s preparation as for train	oletion of coaching or action. shall be the same	V 537			
	This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that 1 of 1 audited former staff (Former Staff #1) completed semi-annual training in seclusion, restrictive interventions and time out . The findings are:  Review on 6-10-25 of Former Staff #1 (FS#1)'s record revealed:  -Hire date 10-9-23, termination date 5-16-25Therapeutic Crisis Intervention (TCI) training					
	restrained dated 5-10 -FS#1 participation Interview on 6-19-25	f a video of Client #1 being l-25 revealed: ng in restraining Client #1. with FS#1 revealed: s she had TCI training				
	revealed:  -FS#1's training vibecause FS#1 was referedFS#1 had been in the last yearThey would make	with the facility supervisor  was probably overlooked egularly in the hospital. in the hospital several times  we sure to monitor the  y in the future so training for o date.				

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PRINTED: 06/24/2025 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING \_ MHL0601171 06/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6750 SAINT PETERS LANE, SUITE 100 YORKE COTTAGE MATTHEWS, NC 28105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Division of Health Service Regulation