

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601482</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/24/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRIST CHURCH COTTAGE THOMPSON CHIL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6722 ST PETERS LANE MATTHEWS, NC 28105</b>		
(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 June 24, 2025. The complaints were substantiated (Intake #NC00231123 and #NC00231120). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 9 and has a current census of 5. The survey sample consisted of audits of 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE