

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/06/2025
NAME OF PROVIDER OR SUPPLIER YORKE COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6750 SAINT PETERS LANE, SUITE 100 MATTHEWS, NC 28105		
(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>INITIAL COMMENTS</p> <p>A complaint survey was completed on 8-6-25. The complaints were unsubstantiated (Intake #NC00232582, #NC00232469, #NC00232399, #NC00232233, #NC00232226). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents.</p> <p>The facility is licensed for six and currently has a census of three. The survey sample consisted of audits of 1 current and 2 former clients.</p>	V 000		

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

TITLE

(X6) DATE