

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL0601400</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/25/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SMITH COTTAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6725 SAINT PETER'S LANE<br/>MATTHEWS, NC 28105</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| V 000                                                    | <p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 9-25-25. The complaint was unsubstantiated (#NC00233415). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 9 and currently has a census of 6. The survey sample consisted of audits or 2 current clients.</p> | V 000                                                                                          |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE