DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-372	B. WING		C 10/17/2	2022
NAME OF PROVIDER OR SUPPLIER AMBER HOUSE 3100 Spring Gastonia, NC			TE, ZIP CODE			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V000	complaint was unsubs Deficiencies were cite This facility is licensed category: 10A NCAC: Staff Secure for Childs This facility is licensed	d for the following service 27G 1700. Residential Treatment	V000			
V296	REQUIREMENTS (a) A qualified profess telephone or page. A cable to reach the facilitimes. (b) The minimum num required when children present and awake is (1) two direct care states one, two, three or four (2) three direct care states for five, six, seven or eadolescents; and (3) four direct care stanine, ten, eleven or twa adolescents. (c) The minimum num during child or adolescents (1) two direct care states and one shall be awake children or adolescent (2) two direct care states and both shall be awake children or adolescent (3) three direct care states of which two shall be asseep for nine, ten, eadolescents. (d) In addition to the minimum to the minimum or the factor or adolescents.	ional shall be available by direct care staff shall be ity within 30 minutes at all aber of direct care staff nor adolescents are as follows: If shall be present for children or adolescents; taff shall be present eight children or If shall be present for children or In the children or the children or In the children or the children or In the children or the children or the children or In the children or the children or In the children or the children or the children or the children or In the children or the ch				
ROVIDER LI	CENSEE OR LICENSEE DES		 TITLE		DATE	

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL036-372	B. WING			7/2022	
	OVIDER OR SUPPLIER HOUSE	STREET ADDR 3100 Spring \ Gastonia, NC					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE DATE	
	the facility based on the individual needs as spelan. (e) Each facility shall be supervision of childrer are away from the face child or adolescent's in needs as specified in a specifie	s evidenced by: ad observation, the facility failed to taffing ratio of two staff for up to findings are: sility on 10-10-22 at approximately and one client (Client #2). ents arrived. I Professional arrived. with Client #2 revealed: staff working per shift. acidents that she knew of. with Client #3 revealed: facility approximately 6 weeks. one staff working per shift at the acidents of clients going AWOL e) or any other incidents that she with Staff #1 revealed: ne. The day of 10-10-22 The had gone out to get some with the Qualified Professional er shift working. The day of 10-10-					