Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-372	A. BUILDING: _____ B. WING _____	R-C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBER HOUSE	3100 SPRING VALLEY DRIVE GASTONIA, NC 28052

(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	INITIAL COMMENTS A complaint and a follow up survey was attempted on 4-24-23. According to the Director there are no clients being served at the facility. The last time client were served at the facility was 2-26-23. This facility is licensed for the following service category: 10A NCAC 27G 1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for three and currently has a census of zero. The survey sample consisted of audits of one former client. Interview on 4-24-23 with the Director revealed: All the clients were picked up by their guardians on the same day which was 2-26-23.	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE