

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-952</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/13/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADRIENNE'S HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4528 CHAMBERSBURG ROAD</b> <b>FAYETTEVILLE, NC 28314</b>
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(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>An annual and follow up was attempted on 08/13/24. According to the Licensee there are no clients being served. The last time clients were served at the facility was 12/20/23.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>During interview on 08/13/24 the Qualified Professional/Licensee revealed the facility had not had clients since December 2023 due to not being able to secure staff. He would contact our agency once he admits any clients in the facility.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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