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 _____	03/11/2025

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 annual survey was attempted on March 11, 2025. According to the Clinical Director, there are no clients being served at the facility. The last time clients were served at the facility was 1/18/24. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. Interview on 3/11/25 with the Clinical Director revealed the Licensee intends to relocate the facility to another location for increased room size the reason no clients are currently being served. The Licensee had not yet identified a new facility location.	V 000		