

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER YODA HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 110 YODA DRIVE GROVER, NC 28073		
(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>INITIAL COMMENTS</p> <p>An annual survey was attempted on May 20, 2025. According to the Director, there are no clients being served at the facility currently. The last time a client was served at the facility was February 12, 2025.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>The facility is licensed for 3 and has a current census of 0.</p> <p>Review on 4/8/25 of Former Client #1's record revealed: -Admission Date: 11/24/24 -Diagnoses: Attention Deficit Hyperactivity Disorder; Oppositional Defiant Disorder; Anxiety; and Depression -Discharge Date: 2/14/25.</p>	V 000		

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

TITLE

(X6) DATE