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 |
|---|---|---|---|
| | MHL036-287 | A. BUILDING: _____ B. WING _____ | R-C 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRACLE HOUSES - TWIN AVENUE | 2004 TWIN AVENUE 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<br><br>A complaint and follow up survey was completed on 7-3-25. The complaints were unsubstantiated (Intake #NC00230550, #NC00231434, and #NC00231567) No deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children And Adolescents.<br><br>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 2 current clients. | V 000 | | |

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