

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER AMBER HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>An annual and follow-up survey was attempted on 8/15/25. According to the Clinical Director, there were no clients being served at the facility. The last time clients were served at the facility was 1/18/24.</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>Interview on 8/15/25 with the Clinical Director revealed:</p> <ul style="list-style-type: none"> - The Licensee no longer rented the home where facility was located. - The Licensee was in the process of trying to locate a new facility. - After the Licensee located a new facility, she would transfer the license to the new address. 	V 000		

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

TITLE

(X6) DATE