

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/16/2025
NAME OF PROVIDER OR SUPPLIER ADRIENNE'S HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4528 CHAMBERSBURG ROAD FAYETTEVILLE, NC 28314		
(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 An annual and follow up survey was attempted on September 16, 2025. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was January 2025. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. Interview on 9/16/25 the Licensee stated: -The facility were not serving clients at this time. -The facility last served clients in January 2025. -The facility had been transferred to another agency. -He would contact the Division of Health Service Regulation to notify of the transfer of ownership.	V 000		

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

TITLE

(X6) DATE