

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 10/21/2025
--	---	---	---

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 October 21, 2025. According to the Licensee, there are no clients being served at the facility.</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>Review on 10/21/2025 of the Division of Health Service Regulation (DHSR) Statement of Deficiency dated 5/20/25 revealed: -An attempted survey on the facility was completed on 5/20/25. -The last client served at the facility was discharged on 2/14/25.</p> <p>Review on 10/21/2025 of an email from the Licensee dated 10/18/25 revealed: -The facility, "had not had any individuals in the home since December 2024." -Confirmed that the last client served at the facility was identified in the attempted survey on 5/20/25.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------