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
	MHL049-131	A. BUILDING: ______ B. WING ______	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REALISTIC CHANGE BY CHOICE WINCHESTE	332 WINCHESTER ROAD TROUTMAN, NC 28166

(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	V 000		

INITIAL COMMENTS

An annual survey was attempted on 6/21/18. According to the Chief Operations Officer (COO)/Qualified Professional (QP) there are no clients currently being served at the facility. The last time a client was served at the facility was in November 2017.

This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.

Observation on 6/21/18 of the facility at approximately 2 pm revealed:
- No vehicles in the driveway of the facility
- A mailbox full of mail (appeared to be advertising flyers, primarily)
- Nothing observable that would indicate clients were currently being served at the facility

Review on 6/21/18 of Former Client #1's (FC #1's) record revealed:
- An admission date of 5/31/17
- Diagnoses of Post Traumatic Stress Disorder (D/O); Rule Out Autism Spectrum D/O; Attention Deficit Hyperactivity D/O, Combined Type; Generalized Anxiety D/O and Conduct D/O, Childhood Onset
- FC #1 was transferred to a sister facility in November 2017
- A discharge date of 3/5/18 from the sister facility

Interview on 6/21/18 with the COO/QP revealed:
- The facility was currently empty with no clients being served
- The facility's last client (FC #1) was transferred to a sister facility in November 2017 and had been discharged from the sister facility

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

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
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V 000	Continued From page 1 on 3/5/18 - The agency would notify DHSR when they began admitting clients to the facility.	V 000		