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 ______	11/01/2018

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 An annual survey was attempted on 11/1/18. According to the Chief Executive Officer/Director of Treatment Services (CEO/DTS) there are no clients currently being served at the facility. The last client was discharged from the facility in November 2017. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. Interview on 11/1/18 with the CEO/DTS revealed: - The facility was currently empty with no clients being served - The facility's last client was transferred to a sister facility in November 2017 and had been discharged from the sister facility on 3/5/18 - She was in the process of completing a change in ownership for this facility as well as its three sister facilities - Two companies were in the process of acquiring all of her facilities - A licensing surveyor from the DHSR had been out to visit and was in the process of completing her responsibilities as part of the change in ownership process.	V 000		

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