STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 complaint survey was completed on 11/26/24. The complaint was unsubstantiated (intake #NC00223565). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, 1 of 1 Qualified professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 11/4/24 of the QP's record revealed: -Hire Date: 8/16/22. -Position: QP, Residential Director. "...The Qualified Professional is also responsible for the oversight of any emergencies...is responsible to perform the clinical, managerial and administrative responsibilities...responsible for the supervision of Associate Professional (AP) and Para-Professionals...The ability to adjust to changes with consumers and within the agency is necessary..." Review on 10/30/24 of Client #1's record revealed: -Age: 14 years old. -Admitted: 7/7/23. -Diagnosis: Disruptive Mood Dysregulation.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 2 Review on 11/5/24 of Client #2's record revealed: -Age: 15 years old. -Admitted: 9/19/23. -Diagnoses: Oppositional Defiant Disorder, Moderate; Adjustment Disorder, With Mixed Anxiety and Depressed Mood; Posttraumatic Stress Disorder, Unspecified; Unspecified Trauma and Stressor Related to Disorder. Review on 11/5/24 of the facility's shift notes for Client #1 revealed: -"...10/26/24...7pm-11:59pm...Caregiver: [AP]...Description of Intervention/Activity: ...greeting to staff and consumers...was given update of consumer's day...engaged in friendly conversation with consumers...observe the consumer taking his shower...observed consumer getting ready for bed...reminded that bedtime was 8:30pm...observed the consumer engage into a situation with another consumer (Client #2). Go to incident report for details. Staff monitored the consumer sleep throughout the night...Digitally signed by [AP]..." -"...10/27/24...7pm-11:59pm...Caregiver: [QP]...Description of Intervention/Activity: ...client spoke about conflict with peer (Client #2)...Staff processed...about rules of the group home...Staff processed...about is health...Staff processed about the consequences of negative behaviors..." -"...10/28/24...3pm-11pm...Caregiver: [#4]...Description of Intervention/Activity: ,,,Staff observed that consumer was looking different (face)...processed with consumer about what was going on...Staff explained to consumer that he needed to work on his behavior...prompt consumer to put some ice on his face...Digitally signed by [Staff #4]..." -"10/28/24...7am-3pm...Caregiver: [AP]...Description of Intervention/Activity: ...Staff	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 3	V 109		

greeted...checked consumer's room for cleanliness...transported and supervised the consumer to school...picked up the consumer from school...observed the consumer's eye was darker...had to redirect consumer once he stated negative comments to staff and a consumer...Digitally signed by [AP]..."
-"10/29/24...7am-3pm...Caregiver: [AP]...Description of Intervention/Activity: ...Staff observed that the consumer's eye was darker than the day before...checked consumer's room for cleanliness...transported and supervised the consumer to school...picked up the consumer from school...Staff was interviewed by a DSS (Department of Social Services) investigator about what took place Saturday night and consumer getting a black eye...Digitally signed by [AP]..."

Review on 11/5/24 of the facility's shift notes for Client #2 revealed:
-"...10/26/24...7pm-11:59pm...Caregiver: [AP]...Description of Intervention/Activity: ...Staff observed consumer taking a shower...observed consumer getting ready for bed...reminded that bedtime was 8:30pm...Staff asked consumer to turn a vape in after another consumer (Client #2) reported he had one. Staff had to redirect the consumer after he punched another (Client #1) consumer for telling staff the consumer had a vape..monitored the consumer sleep...Digitally signed by [AP]..."

Observation on 10/31/24 at 4:57pm of Client #1's face revealed:
-Dark purple, grayish bruise under right eye, that extended from inner left corner near nose to approximately midway under eye area (approximately 0.5-1.0 inch mark).
-Lighter grey coloration in left inner corner that

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	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 4	V 109		

extended to upper left corner of eyelid.
-Lighter purplish-red bruise on upper right side of nose.
-Puffy right cheek with purple, grey and yellowish ombre contusion on bottom of cheek, located approximately 0.5 inch from client's mouth, approximately 1.0-1.5 inches from his lower jawline and approximately 4.0-5.0 inches from his hairline.

Interview on 10/30/24 with Client #1 revealed:
-Face injury was the result of an altercation on 10/26/24 with Client #2.
-"...it's not sore...it's healing."
-Denied he or Client #2 was restrained during the incident.
-"I seen them (staff) do restraints on others and they do it the right way."
-"Staff has never put their hands on me or called me names..."
-"I lied to the teacher about what happened. I just didn't want her in my business."
-"I didn't have two black eyes, just one. She (the teacher) didn't even look at me; that's what happens when you're trying to instigate something."

Interview on 10/30/24 and 11/13/24 with the QP revealed:
-"Provide supervision for everyone that works here (facility) and the therapist also..."
-Made the decision not to take Client #1 for medical care after an altercation between Client #1 and Client #2 on 10/26/24 that resulted in injury to Client #1's face.
-"They (the AP and Staff #3) called me when it (altercation) happened, and I talked to him (Client #1) that night (10/26/27) after they (Staff) got the situation calmed down."
-"We (the AP and staff #3) iced it (Client #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 5	V 109		

face) that particular night (10/26/24) and put ointment on it to get it down."
-"I saw the black eye and bruising on Monday (10/28/24) when he (Client #1) came home from school..."
-"[Client #1] is fair skinned, and they (medical providers) can't prescribe medication to rectify a black eye; it just got to run it's course... we iced it, put [petroleum jelly] on it...never went to the doctor, it's (bruising) progressively looking worse than it did from the beginning."
-"He (Client #1) had an injury, but he wasn't hurt ...it (the injury) didn't deem it necessary...I didn't think it rose the level of need for doctor intervention..."
-"No incident report was made because we didn't take him (Client #1) to the doctor."
-"It was a clear injury from a scuffle, like when playing basketball, so we didn't take him (Client #1) to the hospital..."
-The AP was unavailable for further interview (11/13/24) because he's been hospitalized and " had not shown for work in 2 days."

Interview on 11/14/24 with Client #3 revealed:
-"He (Client #1) wasn't taken to the doctor, [Staff # 4] provided the [petroleum jelly], she's (Staff #4) the only one worried (about Client #1) ...[QP] wasn't worried."
-[Client #1] told me when he touches his face he feels a knot..."

Interview on 10/31/24 with the AP revealed:
-Was supervised by the QP.
-"There was no swelling or anything (on Client #1's face) (10/26/24)."
-"Sunday morning (10/27/24) I checked and didn't see anything (like swelling, bruising)."
-"The next day (Monday morning, 10/28/24) we started to see it (Client #1's face) change (skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 6	V 109		

color)."
-"We didn't put ice on it because he (Client #1) never complained."
-"He (Client #1) went to school Monday (10/28/24) and they (school officials) did what they needed to do (made a report to DSS)."
-"Once we (staff) found out (Client #1 was hurt), when he (Client #1) came back from school, we got him some ice."
"He (Client #1) didn't complain or ask for ice on Tuesday morning."
-"We did not take pictures because we didn't know (that Client #1 was hurt) ...it just turned that color quick."
-"He (Client #1) went to bed Sunday (10/27/24) and woke up Monday (10/28/24), and it (bruising) was there (on Client #1's face)."
-"...the bruising showed up more after a couple of days ...He is quick to bruise because of his fair complexion."
-"We (staff) didn't get medical care because he (Client #1) never complained and kept saying he was okay...he looked okay."

Interview on 11/1/24 and 11/13/24 with Staff #3 revealed:
-"I was told 'if they (clients) say it's okay, it's okay (if clients say they are feeling okay)'...when talking to him (Client #1), I didn't see no signs (that he was in pain)...he (Client #1) kept saying 'it (his face) only hurts when I touch it.'"
-"...that night (10/27/24) around 7pm the kids (other clients) were picking at him about it (his face/the incident). He said, 'it (his face) kind of hurts, but I'm good.'"
-In weekly staff meeting it was discussed whether to take Client #1 to the ER (emergency room).
-"...anyway, we (the AP and Staff #3) concluded based on his (Client #1's) word and called QP (10/26/24), who said 'if he (Client #1) needs to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 7	V 109		

just take him'..."
-"[AP] was like 'if he's (Client #1) okay, he's okay'..."
-"I'm the weekend staff, [AP] takes the kids to school...I'm new and I don't want to go outside my box, I just got here (recently hired) and I don't want to do too much...I figured [AP] drops them (clients) off at school so he would have informed the school (about Client #1's injury)."
-"In my mind, [AP] is not conferring with anyone...he just think he knows."
-"...the night it happened (10/26/24 incident) I gave him (Client #1) ice, that morning (10/27/24) he didn't get ice; I don't think he got ice again (after 10/27/24)."
-"If you want my honest opinion, if he (Client #1) needed to go (to ER) he wouldn't...he's tough and thinks it's (the injury) not a big deal...definitely (wouldn't go to the ER) after he (Client #1) didn't tell the teacher what happened (wasn't honest about the incident) and put his guard up with the teacher..."

Interview on 11/1/24 with Staff #4 revealed:
-"...I think they (staff) should have taken him (Client #1) to be seen (by a medical provider); that was severe if you woke up with bruises..."
-"He (Client #1) has [OTC pain medication] as PRN (as needed), but I don't know if he (Client #1) took one...he didn't take one on my shift...he kept saying it wasn't hurting ...he said he wasn't in no pain...only discomfort, was the swelling on the next day, Sunday (10/27/24)."
-"...he (Client #1) said it was tight or something and he couldn't open his mouth...never said it hurt, if it did hurt, he didn't tell it..."
-"I bought [petroleum jelly] which he (Client #1) been putting on it (face) and it's clearing up. I told him (Client #1) last night he will need to put [petroleum jelly] on his eye. I told him I would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 8	V 109		

help...I think he was scared to get it in his eye ..."
-"No [OTC medication] on my shift."

Interview on 11/1/24 with Staff # 7 revealed:
-"No injury, well [Client #1] had a little mark...I mean he had a bruise on his face; he didn't seem to be bothered, that's the only injury I know..."
-"I seen it (Client #1's face) that following Monday (10/28/24) when I came in at 3pm. It was on his cheek, on his right cheek, like a little bruise on there."
-"...we (Staff #4) gave him (Client #1) some [petroleum jelly] to take the bruising out of it (Client #1's cheek), that worked pretty effectively."

Interview on 11/5/24 with DSS Foster Care Social Worker (SW) revealed:
-Assigned to work with Client #1 since April 2024.
-Sees Client #1 once a month; "...last seen 10/17/24, before his last social worker left."
-Had been made aware of the 10/26/24 incident.
-Was told Client #1 "had a scar around his eye...haven't seen his (Client #1's) injury...I asked for a picture...[QP] told me he would give me one..."
-"Got picture today (11/5/24)...doesn't look like any bruises to me...I don't see any black eyes or anything in this picture."

Interview on 11/19/24 with the Therapist revealed:
-"...what I saw (week following 10/26/24, date unknown) on [Client #1's] face, it (face) was somewhat swollen, and it (swelling) was more so in the cheek area. I didn't see anything around the eye, it (bruise) was more on the cheek area...to me it (cheek) was more of the bruised area."
-"...they (staff) were doing some ice packs...no medical from that, no (facility didn't take him to the doctor for medical care)..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 9 -"... he (Client #1) said he wasn't in any pain; but for me, he could have gotten checked out (by medical provider), but they (staff) said he was fine, they (staff) said he was okay..." -"...did not hear that the 10/26/24 incident with [Client #1] and [Client #2] was related to a restraint." Interview on 11/20/24 with Staff #8 revealed: -When asked who would make the decision that an injury required medical care, "... that would have been done by [QP]...when we call, he usually says he will take care of it." -"...my supervisor (QP) or [President/Licensee] would determine if a child needs to go to the hospital, see a nurse or get medical attention...I would call [QP] for anything like if a child (client) scraped the bed and opened up his leg." Interview on 11/20/24 with Staff #10 revealed: -"I wouldn't know (what the facility policy/protocol is for a client injury)...basically I would take care of the injury, but he (Client #1) said he was fine...usually [QP] would handle those situations, we (direct care staff) don't make doctors' appointments." -"[QP] gave no instructions on care, just said keep an eye on him (Client #1) to make sure he's ok." -" ...only thing I can say is he (Client #1) had something on his cheek, he is light complexion ...that was Sunday (10/27/24), thought it was something from sleeping ...it wasn't a big scar or anything like that ...it was a faint mark on his cheekbone, reddish like if you sleep on your eye too hard ...it wasn't major." -"No one took a picture ...[Staff #3 and AP] just stated there was an altercation." -[AP] did an incident report ...I didn't read it before my shift ...he (the AP) said he was about to write	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 10 it up (10/27/24), so [AP] informed me (of the incident), and [QP] called me and gave an update about the fight and said [AP] would sign the incident report ...it had already been reported (to the QP)." -"...no one gave him [OTC medication] or ice on my shift." Interview on 11/26/24 with the President/Licensee revealed: -Was informed of the 10/26/24 incident involving Client #1 and Client #2 on Monday, 10/28/24. -Had not seen Client #1. -"...it (10/26/24 incident) was staffed on Tuesday 10/29/24...we (management and staff) talked about the incident in the weekly Tuesday meeting." -"...there was no discussion about medical care, he (Client #1) was saying he was fine." -"If the QP felt it was something more than that (serious injury), he (the QP) would have contacted me immediately and we would make the determination (if medical care was needed)." -"if warranted, we take them (clients) to the hospital...if the situation is where they (clients) cut themselves, are not feeling good and they can ask (to have medical care), and we'll take them right away." -"...if anything like this happened again, we'll definitely take them...we'll change the protocol." Review on 11/26/24 of the Plan of Protection dated 11/26/24 written and signed by the President/Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Provider's Quality Management Team (QMT) will coordinate a meeting with all staff to review and	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 11	V 109		

discuss agency's Incident Reporting policy and procedure. All staff will be provided with a re-fresher training on the agency's process for incident reporting. Re-fresher training shall include how to respond to incidents and the process for completing internal incident reporting form and entering Level II and III incidents via IRIS (Incident Response Improvement System). Completion of Training will be done on Dec 5, 2024 by the QMT team . The QMT team is [President/Licensee], [Human Resources] and [Quality Control]. QMT team will also re-train on De-escalation to help with prevention of situation. Staff meeting will be Dec 3, 2024 discussing training for all staff and meeting on adding to the policy and procedures manual.

Describe your plans to make sure the above happens.

-QMT will ensure that all staff attends staff meeting. Staff will be responsible for completing a competency test to ensure that they are aware of how to respond to incidents."

The facility serves four clients with diagnoses of Disruptive Mood Dysregulation, Oppositional Defiant Disorder, Adjustment disorder, Posttraumatic Stress Disorder, and Reactive Attachment Disorder. On 10/26/24, there was an altercation between Client #1 and Client #2. Client #1 sustained a facial injury that included swelling and bruising to his right eye and cheek. The QP made the decision that Client #1's facial injury did not warrant medical attention and the swelling and bruising had to run its course.

This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVES STREET KINGS MOUNTAIN, NC 28086

(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 109	Continued From page 12 within 45 days.	V 109		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by:	V 132		

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V 132	Continued From page 13 Based on record reviews and interviews the facility failed to report to the Health Care Personnel Registry (HCPR) all allegations against health care personnel, including injuries of unknown source, and failed to submit the result of the facility's investigation. The findings are: Review on 10/30/24 and 11/14/24 of the North Carolina Incident Response Improvement System (NC IRIS), from 5/1/24 to 11/14/24 revealed: -No report of 10/26/24 incident between Client #1 and Client #2, which resulted in Client #1 injury. -Internal incident (Level I) indicated details of 10/26/24 incident and reported "no injuries." -Failed to report to HCPR allegation made by Client #1 that he was restrained and beaten up by unknown staff, when made aware on 11/5/24. Review on 10/31/24 of the Facility's Internal Incident Reports from 5/11/24 to 10/31/24 revealed: -Incident report for 10/26/24, "Consumer: [Client #2]; Date of incident: 10/26/24; Time of incident: 8:33pm; Staff reporting: [Associate Professional (AP)]; Level of incident: I; moderate aggression, peer conflict, verbal redirect; counseling; no procedure used; location: bedroom; no injuries; person identified of incident: supervisor; program consequences; signed and dated 10/28/24." -"Incident report for [Client #2] and [Client #1] altercation. On 10/26/24 after 8:33pm (bedtime) staff asked for the tablets to turning in. [Client #2] and [Client #1] was talking in the hallway outside the bathroom. [Client #2] went to his room and informed staff (Staff #3) that consumer [Client #1] still had a tablet in his room. Staff (#3) went to [Client #1] room and asked him for the tablet. Consumer [Client #1] got mad and gave up the tablet and informed staff (#3) that consumer [Client #2] has a vape. Staff (#3) goes to	V 132		

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V 132	Continued From page 14 Consumer's [Client #2] room and asked for the vape. Consumer [Client #2] becomes mad gives up the vape. Consumer [Client #2] ran out his room into [Consumer #1] room and started to hit the consumer [Client #1]. Staff (#3) stopped the consumer [Client #2] and walked him to his room. Staff (the AP and #3) talked with consumer [Client #2] until consumer [Client #2] calmed down." Interview on 10/30/24 with Client #1 revealed: -Face injury was the result of an altercation on 10/26/24 with Client #2. -"...it's not sore...it's healing." -Denied he or Client #2 was restrained during the incident. -"I seen them (staff) do restraints on others and they do it the right way." -"Staff has never put their hands on me or called me names..." -"I lied to the teacher about what happened. I just didn't want her in my business." -"I didn't have two black eyes, just one. She (the teacher) didn't even look at me; that's what happens when you're trying to instigate something." Interview on 10/31/24 with the AP revealed: -"I do Level I reporting, [Qualified Professional (QP)] does IRIS, Level II reporting, also MCO (Managed Care Organization) and HCPR." Interview on 10/31/24 with the QP revealed: -"Learned of DSS (Department of Social Services) report (allegation of abuse) about 2:45pm-3pm on Tuesday (10/29/24), she (DSS Investigator) didn't give me any information (was not informed of allegation that unknown staff restrained and beaten up Client #1). She talked with me at the end of the interviews with the kids (clients)."	V 132		

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V 132	Continued From page 15 -"I didn't know until yesterday that [Client #1] lied and told (school officials) that he fell." Further interview on 11/13/24 with the QP revealed: -"DSS shared that the allegation was about abuse, neglect." -"I was made aware of this (allegation of abuse, neglect) on 10/29/24 when CPS (Child Protection Services) showed up...she (DSS-CPS Investigator) never told me that it (investigation) was abuse or neglect ...I'm just putting those words together." -Thought DSS was investigating Client #1's report to school officials that he was injured from a fall. -Was not aware that Client #1 had also reported to school officials that he was restrained and beaten up by facility staff. -"DSS called 11/5/24 and said the allegation was related to being beat during a restraint, she didn't give any names, that was the first I heard that (on 11/5/24)." -"I don't report anything unless the police are involved, we take the kids (clients) for medical, or restraint is involved." -"I went by (facility) on Sunday (10/27/24), talked (about the incident) to the kids (clients)...they (clients) all told me what happened. -"I just signed off on the incident report that everything was factual ...no, I didn't document an investigation." -Did not report to HCPR when made aware of the Client #1's allegation of unknown staff beating up Client #1 during restraint. Interview on 11/26/24 with the President/Licensee revealed: -"I didn't know the allegation (DSS allegation of abuse) was related to staff abuse ...I thought the school reported that he (Client #1) was in an	V 132		

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V 132	Continued From page 16 altercation and fell ...didn't hear about staff doing anything to him (Client #1)." -Was not aware of Client #1's allegation of restraint and being beaten up by unknown staff. -Was not aware whether report had been made in NC IRIS or to HCPR regarding allegation against facility staff.	V 132		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	V 366		

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V 366	Continued From page 17 (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose	V 366		

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V 366	Continued From page 18 catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to implement written policies governing their response to Level I and II incidents as required. The findings are: Review on 10/31/24 of the Facility's Internal Incident reports 5/11/24 to 10/31/24 revealed:	V 366		

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V 366	Continued From page 19 -Clients #1 and Client #2 altercation on 10/26/24 was documented as "no injuries." -No documentation of a restraint by Staff #7 with Client #4 , September 2024. -No documentation of altercation between Client #1 and Client #4 on 10/27/24 with Client #4 getting scratched on his eye/face. -No risk cause analysis for incidents which occurred September 2024, 10/26/24 and 10/27/24. Review on 10/31/24 of Internal Incident report dated 10/26/24 revealed: -"Consumer: [Client #2]; Date of incident: 10/26/24; Time of incident: 8:33pm; Staff reporting: [Associate Professional (AP)]; Level of incident: I; moderate aggression, peer conflict, verbal redirect; counseling; no procedure used; location: bedroom; no injuries; person identified of incident: supervisor; program consequences; signed (AP and Qualified Professional (QP)) and dated 10/28/24." -"Incident report for [Client #2] and [Client #1] altercation. On 10/26/24 after 8:33pm (bedtime) staff asked for the tablets to turning in. [Client #2] and [Client #1] was talking in the hallway outside the bathroom. [Client #2] went to his room and informed staff (Staff #3) that consumer [Client #1] still had a tablet in his room. Staff (#3) went to [Client #1] room and asked him for the tablet. Consumer [Client #1] got mad and gave up the tablet and informed staff (#3) that consumer [Client #2] has a vape. Staff (#3) goes to Consumer's [Client #2] room and asked for the vape. Consumer [Client #2] becomes mad gives up the vape. Consumer [Client #2] ran out his room into [Consumer #1] room and started to hit the consumer [Client #1]. Staff (#3) stopped the consumer [Client #2] and walked him to his room. Staff (the AP and #3) talked with consumer [Client	V 366		

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V 366	Continued From page 20	V 366		

#2] until consumer [Client #2] calmed down."
-No documentation, wording or description of Client #1's injury in the 10/26/24 internal incident report.
-No amendment to Level I incident report to update regarding Client #1's injury on 10/26/24.
-No findings or amended documentation to address Client #1's allegations of being beaten up while restrained by an unknown staff member.

Interview on 11/1/24 with Staff #3 revealed:
-"On(10/27/24) Sunday during the day, [Client #1 and Client #4] got into it...[Client #4] said, 'I was swinging on him (Client #1)...[Client #4] had a scratch on his eye ...I guess they was playing basketball and [Client #1] was bullying [Client #4] or playing too aggressive...that was not on my shift, that was during day time (1st shift)."

Interview on 11/1/24 with Staff #4 revealed:
-"If an incident happens on your shift..always two staff and between the two of them one of them has to do it (incident report)."
-"I think [QP] looks at it (incident report) ...we (staff) write the report up, he (the QP) looks at it to see if it was done right."
-"...[AP], I'm not sure who determined it (10/26/24 incident) was a level 1 ...[AP or QP]. If he (the AP) didn't write it (incident report), he probably told the other staff, I'm not sure, I don't want to tell no lie."
-"...either [QP or AP] (does IRIS report and determines level of incident) ...[QP] is the supervisor, he checks off, sign off or whatever."

Interview on 11/1/24 and 11/14/24 with Staff #7 revealed:
-He worked second shift.
-"I had to restrain [Client #4] ...sometime in early September (2024, not sure of the date)."

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V 366	Continued From page 21 -"He (Client #4) was being aggressive, so I had to restrain him. It didn't last long. I was like 5 minutes maybe, until he calmed down ...he calmed down pretty quickly and I talked to him about coping." -" ...an incident report was done on the same day (as the restraint in September 2024)." Interview on 11/19/24 with the Therapist revealed: -" ...yes I am aware of when restraints are done ....there have been, in the past ...I would say in September/October maybe ...I think it was probably [Client #4], he had gotten upset, and [Staff #7] had to restrain him (Client #4) ..." Interview on 11/20/24 with Staff #8 revealed: -Recalled "someone getting scratched (10/27/24) ...[Client #4] was playing with his soccer ball, and it went out the door. I was in the kitchen cooking and [Client #4] went out the door to get the ball. [Client #1] went out the door after [Client #4] and [Client #1] went to get the ball. I said, 'hey, y'all come back in here.' When [Client #4] came in he (Client #4) had a scrape on his face; said [Client #1] scraped his face. -"I guess [Client #1] got mad cause he couldn't go outside (due to being on restriction)." -"[Client #1] scratched [Client #4] on his face." -"[Client #4] was crying. I told him to go wipe his face." -"He (Client #4) had a little scrape. I put a band aid on it, called [QP]. I got the first aid kit, wiped his face, put some alcohol and put a band aid on it ("scrape/scratch") ..." -"Thought incident report was done ...not sure when." -" ...called [QP], he didn't say anything about taking out an incident report." -"[AP] may have filed (incident report) when he came in."	V 366		

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V 366	Continued From page 22 -When asked who would be responsible for doing the incident report his shift?, "Don't know if [QP] put it in or [Staff #10] put it in ..." -"As soon as [Client #4] and [Client #1] came in (after the incident), we (Staff #8 and #10) made aware to [QP] ASAP (as soon as possible)." Interview on 11/13/24 with the QP revealed: -Could not recall any restraints done in the facility in the past 3 months. -No incident report for 10/27/24 restraint of Client #4 by Staff #7. "I don't think here was another incident that weekend (10/27/24) ...I didn't hear about that." -Was made aware of Department of Social Services allegation of abuse, neglect, harm on 11/5/25. -Had no documentation regarding attending to the health and safety needs of the client involved in the incident. -Had not developed and implemented corrective measures. -Had not developed and implemented measures to prevent similar incidents. -Had not assigned persons to be responsible for implementation of the corrections and preventative measures. -Had not written and submitted findings to the local Management Entity/Managed Care Organization in the required timeframe.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the	V 367		

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V 367	Continued From page 23 consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident.	V 367		

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V 367	Continued From page 24 (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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	MHL036-406	A. BUILDING: _____ B. WING _____	11/26/2024

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V 367	Continued From page 25 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to submit Level II incident report to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 10/30/24 and 11/14/24 of the North Carolina Incident Response Improvement System (NC IRIS) from 5/1/24 to 11/13/24 revealed: -No documentation for the allegation that Client #1 was restrained and beaten up by an unknown staff person (10/26/24). -No documentation for restraint of Client #4 by Staff #7 (September 2024). -No documentation that the incidents (September 2024, 10/26/24) were submitted to the LME/MCO responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents. Review on 10/31/24 of the Facility's Internal Incident reports revealed: -No documentation of altercation between Client #1 and Client #4 on 10/27/24 with Client #4 getting scratched on his eye/face. Interview on 10/31/24 with the Associate Professional (AP) revealed: -"I do Level I reporting, [Qualified Professional (QP)] does IRIS, Level II reporting, also MCO and HCPR (Health Care Personnel Registry)." -I wrote up the incident with [Client #1] as Level I incident because he wasn't complaining or saying that he was hurting, but [QP] may have done the next steps of reporting."	V 367		

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V 367	Continued From page 26 Interview on 11/1/24 with Staff #3 revealed: -" [AP] wrote the incident report (10/26/24 incident), he (the AP) said he got it (would complete the incident report)..." -"I don't know who decided the report was a Level I incident, [AP] did that (wrote the report), he's (the AP) an older dude, so I just let him run the show...he's (the AP) more respected. -"On (10/27/24) Sunday during the day, [Client #1 and Client #4] got into it...[Client #4] said, 'I (Client #4) was swinging on him (Client #1)'...[Client #4] had a scratch on his eye...I guess they was playing basketball, and [Client #1] was bullying [Client #4] or playing too aggressive...that was not on my shift, that was during daytime (1st shift)." -"I don't know if an incident was written, I didn't check the incident book to see if a report was written, I was working with new staff." Interview on 11/1/24 with Staff #4 revealed: -"If an incident happens on your shift..always two staff and between the two of them one of them has to do it (incident report)." -"I think [QP] looks at it (incident report) ...we (staff) write the report up, he (the QP) looks at it to see if it was done right." -"...[AP], I'm not sure who determined it (10/26/24 incident) was a level 1 ...[AP or QP]. If he (the AP) didn't' write it (incident report), he probably told the other staff, I'm not sure, I don't want to tell no lie." -"...either [QP or AP] (does IRIS report and determines level of incident) ...[QP] is the supervisor, he checks off (incident report), sign off or whatever." Interview on 11/1/24 and 11/14/24 with Staff #7 revealed: -"I had to restrain [Client #4]...sometime in early September (2024, not sure of the date)."	V 367		

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V 367	Continued From page 27 -"He (Client #4) was being aggressive, so I had to restrain him. It didn't last long. I was like 5 minutes maybe, until he calmed down...he calmed down pretty quickly, and I talked to him about coping." -"...an incident report was done on the same day (as the restraint in September 2024)." Interview on 10/31/24 and 11/13/24 with the QP revealed: -"I don't think here was another incident that weekend (10/26/24-10/27/24)...I didn't hear about that " -"I provide supervision for everyone that works here, and the therapist also..." -"No incident report was made (in IRIS) because we didn't take him to the doctor." -"I report to IRIS if there is contact with medical, police are called, or there is a restraint." -Was made aware of the allegations by Client #1 that unknown staff had restrained and beat him up on 11/5/24. -"I'm pretty much the one, myself, that makes the decision for level of reporting...IRIS states to notify if there is aggression...could be verbal, aggression is subjective..." -"I don't report anything unless the police are involved, we take the kids (clients) for medical, or restraint is involved." Interview on 11/26/24 with the President/Licensee revealed: -Contacted the QP to confirm submission of Level II incident report in IRIS for the 10/26/24 incident. -The QP agreed to send NC IRIS confirmation. "I submitted the next day after the police arrived to investigate and talk with [Client #1]. I will take a picture and send it to you." Review on 11/26/24 of photo received from the	V 367		

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V 367	Continued From page 28 QP revealed: -Photo copy of NC IRIS confirmation page that showed date "1/1/0001" in upper right corner to indicate incomplete submission.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 11/13/24 at approximately 1:07pm of the interior and exterior of the facility revealed: Exterior: -Facility gutters, on front side had dead leaves, seedlings (3-4) and debris (twigs). Interior: Client #1's bedroom: -Three cracks in right wall (approximately 16 inches, 3-4 inches and a 3-4 x 2 inch indented area that revealed construction tape/net). -Carpet was matted and soiled with dark (brownish/black) spots (pea sized to approximately 4 x 4 inches diameter) in walking/high traffic areas). Client #2's bedroom: -Bedroom door, dark gray in color, repaired with	V 736		

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V 736	Continued From page 29	V 736		

heavy spackle (globbed, lumpy, uneven) and painted with mismatched lighter gray paint (approximately 1.5 x 2.5 inches).
-Hole (approximately 2 x 5 inches) in wall behind door.
-Carpet was matted and soiled with dark (brownish/black) spots (pea sized to approximately 4 x 4 inches diameter) in walking/high traffic areas).

Client #3's bedroom:
-Smoke detector with connected wires was dislodged, hanging down and not secured to ceiling.
-Carpet was matted and soiled with dark (brownish/black) spots (pea sized to approximately 4 x 4 inches diameter) in walking/high traffic areas).

Client #4's bedroom:
-Five-drawer dresser with missing pulls/knobs (x 5).
-Hole (approximately 2 inches in diameter) in back wall.
-Damaged bedroom door:
-had approximately 10 x 2 inch damaged strip on front lock stile near front door handle; a 15 x 3 inch strip with crack on front bottom hinge stile; frayed on bottom (approximately 0.3 to 1 x 6 inch) and top rail (approximately 1 x 0.3 inch to 2 x 2 inch). Two holes on backside of door near top (approximately 1 X 1 inch and approximately 20-24 inches space between the 2 holes); frayed and cracked around hinge at back of door. Front of door was split/separated on the outer side about a quarter length from the top of the door; and back door frame casing was cracked the length of the frame and half the length of the top frame.
-Indentation in the wall behind the door

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V 736	Continued From page 30 (approximately 3 inch diameter; paint damaged, revealing construction mesh). -Wall indentations had been painted over without repair (ranging in size from a fraction of an inch to approximately 1.5 inch diameter) -Carpet was matted and soiled with dark (brownish/black) spots (pea sized to approximately 4 x 4 inches diameter) in walking/high traffic areas). Hallway bathroom: -Entry threshold missing sill/strip (approximately 1 inch elevation). -Tile above and around sink with brownish linear stains/residue the length of the back wall around the sink and the adjacent right wall. -Dark brownish/discolored splatter stains/spots on tile around toilet (fraction of an inch to pea-size). -Popcorn-type ceiling with multiple brownish/black/grayish splotches (ranging from a fraction to approximately 3 x 4 inch areas) -Ceiling with hole (approximately 1 x 1 inch diameter) and areas with peeling (approximately 1-3 inches in length). -Rust around ceiling light fixture. -Area on wall around tub (approximately 0.5 x 2 inches) with dark/black color and crack in tile at top right corner of tub. -Bathroom door (approximately 4 x 4 inches), repaired with heavily globbed, lumpy spackle and mismatched grey paint (approximately 10 x 10 inches) on brown door. Interview on 11/14/24 with Client #2 revealed: -"Nothing needs to be fixed (in the facility)...not that I know of...that hole (referring to a hole in his bedroom wall) happened the first week I got here...I was mad because they took me (removed from family)..."	V 736		

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V 736	Continued From page 31 Interview on 11/14/24 with Client #3 revealed: -"The house (needs repair), mostly the rooms (bedrooms) have a lot of holes ...painter got the wrong color (mismatched touch-ups) ...doesn't look good in the house." -"[Client #4]'s door, the frame is split so it screeches when opening." Interview on 11/14/24 with Client #4 revealed: "...that (holes and damaged door) was there when I got here (Admitted 7/31/24)." Interview on 11/20/24 with Staff #10 revealed: -"No repairs needed" at the facility..."[QP] handles it (arranging for repairs)." Interview on 11/20/24 with Staff #8 revealed: -"No repairs needed, [QP] usually goes through or has other employees to make sure things are secure...if anything needs to be fixed, we report that to [QP]." Interview on 11/13/24 with the Qualified Professional (QP) revealed: -"We (facility) had been trying to get the landlord to do some repairs ...we just purchased the house about 2 months ago and were starting to do some repairs..." -"We usually paint once a year; that's coming up soon..." -"We have a man who comes in and does the touch ups (repairs)..." -"That ceiling in the bathroom looks like that (brown spots and peeling) because of the water..." -"That water (from shower use) does that to that popcorn ceiling..." -"...we can do that (fix)...we can replace that (door and frame in Client #4's bedroom)."	V 736		

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V 736	Continued From page 32 -Unable to make dislodged smoke detector stay in place..."He (maintenance) can fix that." Interview on 11/26/24 with the President/Licensee revealed: -"I hire an outside guy that does repairs...[QP] will contact the guy and have him do repairs and I pay him." -"This is the first year and we're doing an overhaul in the house (facility)..." -"We were renting and purchased the house (facility) about a month ago...October."	V 736		