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
	MHL034-380	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARPE AND WILLIAMS #8	937 GLENCOE STREET WINSTON SALEM, NC 27107

(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 A limited follow up survey for the Type A1 was completed on April 23, 2019. This was a limited follow up survey, only G. S. 131E-256 Health Care Personnel Registry (V132) and 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) were reviewed for compliance. The following were brought back into compliance: G. S. 131E-256 Health Care Personnel Registry (V132) and 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512). No deficiencies were cited. This facility is licensed for the following service category : 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		

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