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
	MHL034-254	A. BUILDING: ______ B. WING ______	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE & JACKSON GROUP HOME - II	3913 INDIANA AVENUE WINSTON SALEM, NC 27105

(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 follow up survey was attempted on August 17, 2021. Interview on 8/17/21 with the Chief Executive Officer/President/Licensee/PP (CEO/P/L/PP) revealed: -The facility had not had any clients since February 3, 2020, when the last client was discharged. -Was not sure why her cell phone would not accept messages. -Stated she would clear out her voicemail on her cell phone. -Wanted to keep her license valid through December 31, 2021. -Hoped to screen clients for admission in the very near future. -Would call this surveyor the moment she admitted clients to the facility. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		

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