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			
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		OOM! E			
		MHL034-357	B. WING		12/03/2021			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SHARPE A	AND WILLIAMS #6	4790 LENN WINSTON	IOX ROAD SALEM, NC 2	7105				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 000	INITIAL COMMENTS	}	V 000					
	An annual survey was deficiency was cited.	s completed on 12/3/2021. A						
		d for the following service 27G .5600A Supervised Mental Illness.						
	The survey sample cocurrent clients.	onsisted of audits of 3 of 5						
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736					
		EMENTS						
		ns and interview, the facility n a safe, clean, and orderly						
	approximately 1:40PN Kitchen: - Cabinets: lower had one corner cabinet wa	cility and it's ground at M on 11/30/2021 revealed: I stains on bottom of shelf, as hanging loose from I and drawer pull on one						
	drawer near sink - Fridge/freezer had obrackets	door shelves missing front						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-357	B. WING		12/03/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARRE	AND WILLIAMS #6	4790 LENI	NOX ROAD			
SHARPE	AND WILLIAMS #6	WINSTON	SALEM, NC 2	7105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 736	Continued From page	e 1	V 736			
V 736	AND WILLIAMS #6		V 736			
	Garage: - A fridge/freezer was garage - The walls and ceiling unfinished/unpainted - An upright freezer w	stored unplugged in the g had spackling and drywall vas plugged in and contained				

Division of Health Service Regulation

layers of ice on all shelves

STATE FORM STATE FORM SJGC11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7. BOILDING.	A. BUILDING.				
MHL034-357		B. WING	B. WING		12/03/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE			
SHARPE	AND WILLIAMS #6		INOX ROAD N SALEM, NC 2'	7105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 736	rail, peeling paint over damaged floorboard to the damaged floorboard to the later of paints were not thought facility staff merson. - He took care of plum plunging the toilet who the later of plumplunging the toilet who the later of plumplunging the toilet who the later of plumplunging the toilet who linterview on 12/1/202 - Everyone at the facility at present doors in broken "for a while." Interview on 12/1/202 - If the facility needed "state representation - He did not know of a facility at present. - The mildew in the basevery three or four darent of the later of	loose boards on top of the r the entirety and one that created a trip hazard. 21 with Client #1 revealed: needed at the house, he night call a maintenance inbing issues himself by en needed. 21 with Client #2 revealed: lity had chores around the any mildew in the bathroom. In his bedroom had been in the staff could call workers." 21 with Client #3 revealed: lity had chores around the any mildew in the bathroom. In his bedroom had been in the staff could call workers. In the staff could call workers. In the staff could call workers. In the damaged boards on the damaged boards on the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the damaged boards on the staff #1 revealed: In the staff was a staff with the staff #1 revealed: In the staff #1 re	V 736				
		21 with Staff #2 revealed: rooms to ensure that they					

Division of Health Service Regulation

STATE FORM STATE FORM SJGC11 If continuation sheet 3 of 4

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL034-357	B. WING		12	/03/2021	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4790 LENNOX ROAD WINSTON SALEM, NC 27105						
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 736	made their beds. - A new bed frame ha assembled by facility bed in one of the clier. - He did not realize th was in the bathroom. - When repairs were rewould contact the QP. Interview on 12/3/202. - Facility staff and clied the facility. - New furniture was or items.	d been ordered and staff to replace the broken nt's bedrooms. e amount of mildew that needed at the facility, he 1 with the QP revealed: ents were supposed to clean ordered to replace the broken 1 with the Director revealed: ready been made at the	V 736				

Division of Health Service Regulation

STATE FORM STATE FORM SJGC11 If continuation sheet 4 of 4