PRINTED: 11/14/2022 FORM APPROVED

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					
				D WING		R-C						
MHL019-074			B. WING			11/01/2022						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
SHARPE AND WILLIAMS BOOTH ROAD GROU 130 BOOTH ROAD CHAPEL HILL, NC 27516												
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	CTION SHOULD BE COME O THE APPROPRIATE DA						
V 000	INITIAL COMMENTS			V 000								
	A complaint and follow-up survey was completed on November 1, 2022. The complaint was unsubstantiated (intake #NC00193229.) A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.											
		sed for 6 and currently urvey sample consisted client.										
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736									
	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.											
	failed to ensure faci	et as evidenced by: on and interview, the f ility grounds were mair I attractive manner. Th	ntained									
	Room revealed:	1/22 at 12:10 PM of the	_									
	Observation on 11/2	1/22 at 12:12 PM of the	e Dining									

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL019-074	B. WING		R-C 11/01/2022		
	PROVIDER OR SUPPLIER	OTH ROAD GROU		STATE, ZIP CODE			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
V 736	-Floors needed to be debris. Observation on 11, Kitchen revealed: -Wooded frame from issing. Observation on 11/Bathroom with Sho-There was a strong-Floor was wet from Floor inside the ship possible mold/milded. Observation on 11/Bathroom with Tub-Caulk on sides of the Missing at some arpossible mole/milded. Floor inside the tule-Toilet was shifted the Bottom of toilet has and stained black with the William of toilet has and stained black with the William of toilet has and stained black with the William of toilet has and stained black with the William of toilet has and stained black with the William of toilet has and stained black with the William of toilet has and stained black with the William of t	de swept as there was visible 21/22 at 12:15 pm of the 21/22 at 12:20 pm of the 22 at 12:20 pm of the 23 wer revealed: 25 g urine smell. 26 urine on the floor. 27 ower had dark stains from 28 ower had dark stains from 28 ower had stained black with 29 was stained/dirty. 20 the left. 21 d caulk missing at some areas 22 with Staff #2 revealed: 23 sponsible mole/mildew. 24 with Staff #2 revealed: 25 sponsible for cleaning the 26 told to clean the bathrooms 26 told to clean the bathrooms 27 with Staff #2 revealed: 28 sponsible for cleaning the 29 told to clean the bathrooms 20 told to clean the bathrooms 21 with Staff #2 revealed: 22 with Staff #2 revealed: 23 completed. 24 on the floor inside the shower 25 d made some repairs and 26 rials on the flooring. 27 ng to gump up and looked 28 terials had been used. 28 dged that facility failed to 28 nds were maintained in a	V 736				

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