STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X2) PROVIDER/SUPPLIER/		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
				R-C				
MHL034-324		B. WING		09/21/2023				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
SHARPE	SHARPE AND WILLIAMS #3  4419 CANAAN PLACE WINSTON-SALEM, NC 27105							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE		
V 000	INITIAL COMMENT	-s	V 000					
	on 9/21/23. The co	low up survey was completed mplaint was substantiated 259). Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.  This facility is licensed for 6 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.							
V 736	27G .0303(c) Facilit	ty 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.							
		on and interview, the facility ned in a safe, attractive, and						
	3:12 pm and 4 pm r Living room:  - The vent cover was covered in dus Kitchen:  - The folding doo the knob used to op Client bathroom:  - A rectangular a bathroom sink was	for the heating and air system t or to the pantry was missing						

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

TITLE (X6) DATE

Division	<u>of Health Service Re</u>	egulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
		D WING		R-		
		MHL034-324	B. WING		09/2	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY. S	STATE, ZIP CODE		
			AAN PLACE			
SHARPE	AND WILLIAMS #3		I-SALEM, NO			
			I-SALLIVI, INC			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
170			170	DEFICIENCY)		
	<b>.</b> –					
V 736	Continued From pa	ge 1	V 736			
	- Dried drip stain	s (yellowish in color) on the				
	wall and behind the					
		s (yellowish in color) on the				
		light switch and beneath it				
	Hallway bathroom:	nghi switch and beneath it				
	_	was covered with rust				
	colored specks	was covered with tust				
	•	am.				
	Empty client bedroo					
	- A drawer was missing from a four drawer					
	dresser					
	Client #2's bedroom					
	- A two door wardrobe with the veneer coming					
	loose from one side					
	Client #3's bedroom:					
	- A five drawer vinyl storage container with an					
	amount of clothing/items stuffed into each drawer					
	which did not allow the drawer to be closed					
	completely					
		her items strewn along the				
		nd in corners of the closet				
	and spilling out of p					
		llow dresser covered with the				
		longings, which included 18				
		, lotion, hand sanitizer,				
		etal bowl, a stuffed animal and				
	other items					
		f shoes/sandals sitting against				
		ems including stuffed animals				
	sitting in a pile on th	ne floor				
		3 and on 9/21/23 with the				
	Qualified Profession					
		ployed a maintenance man				
		le for making repairs at the				
	facility					
		urvey completed on 6/22/23,				
		ne maintenance man with				
		of concern and he had been				
	working to make all					
	- When she visited the facility, she noted any					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL034-324		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			R-C <b>09/21/2023</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SHARPE	E AND WILLIAMS #3		IAAN PLACE I-SALEM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	needed repairs and maintenance man/o any issues that needed. Staff were also messaging system anything that needed. If the maintenarepair, the owner of who could. Staff were responded who could. Staff were responded who could. Client #3 had a clothing and shoes her things which conclothing, shoes and shoes her things which conclothing, shoes and shoes her things which conclothing and spoke condition of her room with staff about assertion in order. She also plannlegal guardian on heregarding the amounts she had acquired a of items she no lon. This deficiency has	I followed up with the owner of the facility regarding ded to be addressed to notify her via an internal ("Slack") if they observed ded to be repaired nee man could not make the the facility hired someone onsible for ensuring the facility to assist clients when needed penchant for purchasing and her legal guardian gave ntributed to her collection of	V 736			
V 754	EQUIPMENT (c) Comfort Zone: provide heating and maintain a comfort degrees Fahrenhei (1) This requ	Each 24-hour facility shall dair-cooling equipment to range between 68 and 80	V 754			

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	of Health Service Re	eguiation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:			
						_
			B. WING		R-C	
		MHL034-324	b. WING		09/2	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
NAME OF	TOVIDER OR OUT LIER					
SHARPE	AND WILLIAMS #3		AAN PLACE			
		WINSTON	-SALEM, NO	27105		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
V 754	Continued From pa	ige 3	V 754			
-						
	24-hour facilities for	r six or fewer clients.				
	(2) Facilities	licensed prior to October 1,				
	1988 shall not be re	equired to add or install cooling				
	equipment if not alr	eady installed.				
		•				
	This Rule is not me	et as evidenced by:				
		ion and interview, the facility				
		ed with heating and air-cooling				
	equipment to maintain a comfort range between 68 and 80 degrees Fahrenheit. The findings are:					
	oo and oo degrees	raniennen. The indings are.				
		8/23 at 3:12 pm of the facility's				
	thermostat revealed: - A temperature reading of 81 degrees - Portable electric fans were placed in the living room, the kitchen and in the clients' (#1, #2 and					
	#3) bedrooms	,				
	,					
	Interview on 9/18/2	3 with client #1 revealed:				
		t's been about a month since it				
		stem) stopped working."				
		able electric fan in her				
	bedroom for her us					
	- "Gets a little ho					
	- Gets a little 110	un nere.				
	Interview on 0/40/0	2 with alignt #2 revealed:				
		3 with client #2 revealed:				
		the air conditioning system				
		owever, she had no concerns				
		provide a date as to when the				
	system stopped wo					
		fan in her bedroom for her				
		d her window at night which				
	kept her comfortable	le				
	Interview on 9/19/2	3 with client #3 revealed:				
	- The air condition	oning system had been				
		er, it had stopped working				
		nade to the system and it				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C		
MHL034-324		B. WING		09/2	1/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHVDDE	AND WILLIAMS #3	4419 CAN	AAN PLACE	<u> </u>		
JIIAKEL	AND WILLIAMS #3	WINSTON	I-SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 754	Continued From pa	ge 4	V 754			
	began to work again; but stopped working for a second time - She could provide no exact timeline as to how long the system had been in a state of disrepair					
	Interview on 9/19/23 with staff #1 revealed:  The air conditioning system had been "out a couple of weeks."  It had stopped working, was repaired, and stopped working for a second time  The first time it stopped working, it only needed "coolant"; however, this time, it needed more than "coolant"  She knew a repair person had been to the facility to address the issue; however, she was unsure as to what the status of the repair was at the present time  All the clients had electric fans in their bedrooms, and she kept the blinds drawn throughout the facility to keep the sun from heating the inside of the facility  The only time it got warm in the facility was when she was cooking  None of the clients had complained to her about the temperature in the facility					
	Interview on 9/21/23 with the Qualified Professional revealed:  - The air conditioning system had stopped working earlier in the summer; however, it was repaired  - The system had stopped working a second time on 9/13/23  - She notified the Owner of the facility on 9/13/23 via email and was informed by the Owner, she would request a repair person come to the facility on 9/14/23  - They were still waiting for someone to come to the facility to address the issue as of 9/21/23					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		A. Boilbino.		R-C					
		MHL034-324	B. WING		1	1/2023			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SHARPE	SHARPE AND WILLIAMS #3  4419 CANAAN PLACE WINSTON-SALEM, NC 27105								
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE			
V 754	Continued From pa	ge 5	V 754						
V 754	•	w up with the Owner again	V 754						

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