

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-276</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/12/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOLFE &amp; JACKSON GROUP HOME, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>744 EAST SPRAGUE STREET</b> <b>WINSTON-SALEM, NC 27107</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow-up survey was attempted on 8/12/25. According to the Owner, there had been no clients served at the facility since the last attempted annual and follow-up on 3/21/25. The last time clients were served at the facility was 12/31/24.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Interview on 8/12/25 with the Owner revealed she was no longer able to license the facility because of her and her husband's health concerns.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE