STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-334	A. BUILDING: _____ B. WING _____	08/08/2018

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NOA HUMAN SERVICES #3	1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106

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V 000	INITIAL COMMENTS A Complaint Survey was completed on August 8, 2018. The complaint was substantiated (intake #NC00140326). Deficiencies were cited. This facility is licensed for the following service category: - 10A NCAC 27G .5600A: Supervised Living Group Home for Adults with Mental Illnesses	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.	V 291		

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V 291	Continued From page 1 Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to serve no more than six clients, when the clients have mental illness or developmental disabilities. The findings are: Review on 7-26-18 of an email from client #1 ' s legal guardian (LG1) revealed: - on 6-19-18 he was visiting his client at the facility - he counted 9 total clients at the facility - he counted only 1 staff person. Interview on 7-25-18 with LG1 revealed: - he witnessed 9 clients there on one occasion - he was there in the daytime - he was not there at night Interview on 7-25-18 with staff #1 revealed: - approximately 2 months ago there were 8 clients at the facility - upon further questioning, staff #1 stated he did not understand the question and retracted, stating they had never served more than 6 clients Review on 8-8-18 of incidences revealed: - an event on 7-26-18 involving a client from a sister facility - client became belligerent and threw his medication	V 291		

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V 291	Continued From page 2 - time of incident was 9:06 am Interview on 8-8-18 with the Qualified Professional (QP) revealed: - there were times when clients from sister facilities may be combined for activities such as cookouts - these events helped build social skills - when asked about the time (9:06 am) of the incident on 7-26-18 the QP reported there were also times when staff from sister facilities might drop off a client when taking other clients to doctor ' s appointments - some clients came from a sister facility and were taken to two other facilities, including NOA Human Services #3, "but no clients were spending the night. The repairs to the facility were made the same day." - further interview with the QP revealed, he understood that made him out of compliance for the required ration of staff to clients - in the future he would bring extra staff to insure he would not be out of ratio - "I understand, I ' ll correct it."	V 291		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 3	V 367		

becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

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V 367	Continued From page 4 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to report all level II incidences that occur during the provision of billable services, for one of three clients (client #1) surveyed. The findings are: Review on 7-25-18 and 8-8-18 of client #1 ' s	V 367		

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facility record revealed:
- he was admitted 11-2-15
- he was 66 years old
- he was diagnosed with:
  - Intellectual Disability, Moderate
  - Persistent Depressive Disorder
  - Impaired Cognition
- admission assessment on 11-2-15 with the following findings:
  - motor skills, appearance, behavior within normal limits
  - speech is pressured
  - dislikes household noises
  - prefers diet of ice cream and snacks
- treatment plan dated 11-1-17 with goals:
  - increase independence by managing his time in the home and community
  - maintain supportive living environment
  - learn to control behavior in the home and community
  - stop getting agitated when told "No"
  - under the heading, "What ' s Not Working" client #1 states:
    - "I keep being told by staff that I cannot go to the store by myself, which I don ' t see anything wrong with me going."

Review on 8-8-18 of incident reports from 2-1-18 to 8-8-18 revealed:
- no event involving client #1 falling during a snowy outing when he left the facility unsupervised and was returned to the facility by a police officer

Interview on 7-25-18 with staff #1 revealed:
- client #1 leaves the facility regularly
- "He does well going out."
- "I think he did fall once, I ' m not sure -wasn

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V 367	Continued From page 6 ' t working." Interview on 8-8-18 with the Qualified Professional (QP) revealed: - I think he fell 4 or 5 months ago (date not given) - "He showed me his knee, but he wasn ' t hurt." - When asked if he falls frequently? - "No, no he doesn ' t" - if the incident had been recorded, it would be, "in my book." - "I encourage staff to fill those out" - stated, "I never heard of police bringing Mr. [client #1] back from being out in the community" - When asked if client #1 ' s legal guardian informed him he stated: - "No, I never heard of that. Of course, that would be a level II, that I don ' t have any information on." Review on 7-26-18 of an email dated 7-26-18 from client #1 ' s legal guardian (LG1) revealed: - he met with client #1 on 3-23-18 - at that meeting client #1 informed him " ...of a fall that happened when [client #1] was walking to the store during snowy weather. Police brought [client #1] back to the facility according to NOA (NOA Human Services #3) staff ..." Further review on 7-26-18 of an email dated 6-14-18 from the QP to LG1 revealed: - "NOA Human Services (LLC) is not a lock down facility and we cannot restrict [client #1] not to go to the store if (he) chooses. I have explained this to you and have developed an unsupervised document as you requested that I sent for your review ... at this point staff can only encourage [client #1] to not live (leave) on his	V 367		

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V 367	Continued From page 7 own ... You have advised that we should call the police from now on if he does, but remember I have to complete incident report for the state whenever this happens, and this is not a great record for our agency."	V 367		