Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	=1ED	
		MHL034-381	B. WING		10/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	10/2	0/2010
			KESDALE AVE	,		
NOA HUM	AN SERVICES #4		SALEM, NC 2			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
V 000	INITIAL COMMENTS	1	V 000			
	on October 26, 2018.	aint survey was completed The complaint (Intake unsubstantiated. A deficiency				
	_	d for the following survey 27G .5600A Supervised Mental Illnesses.				
V 109	27G .0203 Privileging	g/Training Professionals	V 109			
	10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10 A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures					

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

(X6) DATE TITLE

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, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(3) DATE SURVEY COMPLETED	
MHL034-381		B. WING	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		0/26/2018	
NO 4 111119	AN 050 #4	4328 ST0	OKESDALE AVENU	E			
NOA HUN	IAN SERVICES #4	WINSTO	N SALEM, NC 271	01			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 109	Continued From page	e 1	V 109				
	plan upon hiring each (g) The associate pro supervised by a quali	fied professional with the the period of time as					
	Qualified Professiona to demonstrate the kr required by the popul clients (#1, #2 and #3	ews and interviews, 1 of 2 als/President (QP#2/P) failed nowledge, skills and abilities ation served effecting 3 of 3 b). The findings are: of the QP #2/P's record					
	-A hire date of 7/18/1 -A job description of F -A conviction for felor minor on 12/17/13 -A violation of probati to notify law enforcen	Paraprofessional by indecent liberties with a con, dated 8/8/17, for failure the nent of an address change.					
	Type, Hypothyroidism Severe, Cannabis Us Cocaine Use Disorde -An assessment date	f 8/1/18 phrenia Disorder, Bipolar n, Alcohol Dependence, e, Disorder, Severe and r, Severe.					

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		MHL034-381	B. WING		10	/26/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE			
		4328 STC	OKESDALE AVENU	JE			
NOA HUN	IAN SERVICES #4		N SALEM, NC 271				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
V 109	Continued From page	e 2	V 109				
	takes monthly shots.	history of depression, needs					
		participate in activities,					
		disorganization of thoughts,					
		s, prior to placement, no					
		use issues since 2016, her					
	poor decisions placed	d her at high risk for					
	exploitation and sexu	ally transmitted diseases."					
	-A treatment plan dated 8/1/18 noting "will						
	increase her indepen						
	_	ne group home, obey all the					
	_	of the facility each day, will					
	learn appropriate behaviors and communication						
		planned social activities with					
	her peers at least once a day, will improve her hygiene by taking daily showers. Cleaning up						
	after herself and doin	g assigned chores."					
	Review on 10/25/18 of client #2's record revealed:						
	-An admission date o	f 8/1/18					
	-Diagnosis of Schizoaffective Disorder, Bipolar Type						
	••	d 8/1/18 noting "has brain					
		ns, needs assistance with					
	_	medication management,					
		mediation administration,					
		nia and bizarre delusions					
	and family is importar	nt to him."					
	-A treatment plan dat	ed 8/1/18 noting "within the					
	next 90 days, client w	vill abide by the rules and					
		ility, will learn life and daily					
		e independent, will learn how					
		r in the home and the					
	_	et agitated when told no, will					
	attend all scheduled appointments and other professional appointments and will take all						
medications as prescribed, will increase his independence by learning to manage his supervised time in the group home and the community over the next 12 months to assist with							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
MHL034-381		B. WING		10/26/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NOA HUM	AN SERVICES #4	4328 STO	KESDALE AVE	NUE		
		WINSTON	SALEM, NC 2			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 109	Continued From page	e 3	V 109			
	building and integrate social skills and will learn to care for self."					
	Review on 10/25/18 or revealed:					
	-An admission date o					
	-Diagnoses of Schizophrenia Disorder, Bipolar Type, Asthma, Diabetes Mellitus and					
	Schizoaffective Disor					
	-An assessment dated 8/18/18 noting "history of hallucinations, thoughts are disorganized, 2 prior					
	hospitalizations, has paranoid delusions in the					
	context of violent behaviors, makes several statements/references to the distrust of others,					
		physical aggression when				
		sis, On 3/15/18 previously				
	attacked a staff mem	her head, grabbing her				
		the floor and kicking her."				
	-A treatment plan date					
		dence while learning to				
	manage his behaviors during supervised time in the group home and community, will abide by the rules and regulations of the facility, learn life and					
	activities of daily living and how to be independent as instructed by staff, will learn how to control his					
	-	e and community, will not				
		d no, will attend all medical				
	appointments and tak prescribed."	ce medications as				
	Interview with staff #1	revealed:				
		of Felony Indecent Liberties				
	with a Minor -Acknowledged he was a registered sex offender -Stated he failed to notify law enforcement of his					
change of address. -"I made a decision I deeply regret." -Had told the QP#2/P he was a registered sex		July law chilorochilotti of file				

Offender
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL034-381		B. WING		10	10/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
NOA HUN	IAN SERVICES #4		KESDALE AVEN			
	T	WINSTON	SALEM, NC 27	7101		
(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 109	Continued From page	e 4	V 109			
	-Was concerned with -Was not sure if the Corime of Felony IndecentailedWould immediately gensure she was awar conviction -Would discuss with the staff #1 to an all-male. Interview with the QP-Wanted to give staff -Was aware staff #1 Indecent Liberties with -Felt it was okay to his work with children. It due to 'groping' a little	was a registered sex for hiring staff he decision to hire staff #1 staff #1's conviction QP#2/P was aware of the cent Liberties with a Minor get with the QP#2/L to re of the meaning of his the QP#2/P about moving e facility (sister). P#2/P revealed: #1 a second chance had been convicted of th a Minor in 2013 ire him "because he doesn't chought his conviction was e girl. I did not know it meant e rape or anything like that.				

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