STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 05/02/2019

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NOA HUMAN SERVICES, INC	4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101

(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	INITIAL COMMENTS A complaint survey was completed on May 2, 2019. The complaints (Intake #NC00150668, #NC00149814, and #NC00151097) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illnesses.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on records review and interviews, 1 of 3 staff audited (staff #1) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 5/2/19 of staff #1's record revealed: - Date of hire: 12/20/17 - Position: Direct Care Staff Interview on 5/2/19 with staff #1 revealed: - On 4/24/19 client #1 and client #2 were outside smoking cigarettes on the porch. - Client #2 came in and informed him that client #1 had walked away. - He was the only staff member working when client #1 walked away. - He found client #1 next door at the neighbor's home. - This was the only time client #1 had walked away from the group home. - He did not complete an incident report and did not tell the Owner or the Qualified Professional about the incident. - "I was in the house cooking (on 4/24/19) a little after 7 pm and they (client #1 and client #2) go outside to smoke cigarettes. [Client #2] came inside and said [Client #1] walked off. I went outside and saw him (client #1) next door. He was walking towards me and I told him to get back in the house." - "After that I told him (client #1) that was not right to do. Later that night the police came over to	V 110		

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V 110	Continued From page 2	V 110		

speak about the situation."
- "The police asked me did you know that he went over there and I explained prior to that no I didn't have knowledge. Initially I did not know he (client #1) walked away until [client #2] told me."

Review on 5/2/19 of local police department's "Incident Investigation Report" dated 4/24/19 revealed:
- "Upon arrival we met with the [the neighbor] who told us an unknown male had entered her home."
- "[The neighbor] told us she believes the man lives at the group home ..."
- "We went next door to [address of group home] and made contact with the caregiver at the home [staff #1] who said he had no knowledge of any of his residents leaving the property. When we described the man who had entered [neighbor's] home he called a [client #1] outside. [Client #1] seemed generally confused and when we asked why he had gone next door, he said his brother [brother's name] lived there, and he was looking for him."
- "We told [Client #1] not to return to [neighbor's] house, and we told [staff #1] to try and keep a closer eye on [client #1]."
- "No further action was taken."

Interview on 5/2/19 with the Qualified Professional revealed:
- He had no knowledge that client #1 walked away from the group home on 4/24/19.
- Reviewed the incident report notebook and found no incident report from 4/24/19.
- On 4/24/19 only staff #1 was working.
- Client #1 had a goal for unsupervised time but unsupervised time was only utilized when the legal guardian approved the client to be with family members in the community. Client #1 was never left alone.

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V 110	Continued From page 3 Review on 5/2/19 of the group home's Incident Reports revealed: - No incident report was completed on 4/24/19. Review on 5/2/19 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No incident report was entered into the IRIS system about the 4/24/19 incident. Interview on 5/1/19 with client #1 revealed: - He went to the neighbor's home but could not provide a time frame. - "I went one time (to the neighbor's home). I know those people." Interview on 5/2/19 with Client #1's Legal Guardian revealed: - She had not been contacted by the group home staff about the 4/24/19 incident involving client #1 and the police being called. - "No, no one from the group home contacted me (about the police being called on 4/24/19). I talked to the QP (Qualified Professional) on 4/26 (2019) and he never mentioned the police being called."	V 110		
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	V 291		

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V 291	Continued From page 4 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. 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 record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment, affecting 1 of 2 clients (client #1). The findings are: Review on 5/1/19 of client #1's record revealed: - Admission Date: 3/15/18 - Diagnoses: Schizophrenia, Paranoid Type; Post-Traumatic Stress Disorder - Review of client #1's goals in the Person-Centered Profile (PCP) updated 4/17/19 revealed: - " ...will abide by the rules and regulations of the facility, learn life and daily living skills (ADLs) (Activities of Day Living), how to be independent	V 291		

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V 291	Continued From page 5 as instructed by staff ..." - " ...will learn how to control his behavior in the home and community and stop getting agitated when told no, and attend all scheduled doctors and other professional appointments, take all medication as prescribed by his doctors ..." - " ...will increase his independence by learning to manage his unsupervised time in the group home or in the community each day ..." - It was noted the process of achieving this outcome was: "not much progress still working on stabilizing my medication ..." - There was no documentation in his record about increased urination/bedwetting. Interview on 5/2/19 with the Director revealed: - Client #1 started wetting the bed, "about a week or two ago." - Could not provide documentation that client #1 had been taken to a medical provider about his recent bedwetting. Interview on 5/2/19 with the Qualified Professional revealed: - Reported that client #1 started bedwetting for the first time "middle of last month (April 2019)." - He was unable to provide any documentation or medical records that showed client #1's bedwetting had been discussed or addressed by a medical professional. - Currently was wearing Depends that the group home supplied, not Medicaid. Interview on 5/2/19 with Client #1's Legal Guardian revealed: - She first met client #1 on 4/11/19. - She had requested records from the group home but had not received them. - She was aware client #1 had started bedwetting. - She reported that client #1 had not been taken	V 291		

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V 291	Continued From page 6 by the group home to a doctor for his bedwetting. Interview on 5/1/19 with client #1 revealed: - He wore Depends "just at night." - Could not provide any details about when he started wearing Depends at night or if he had been to a medical doctor about his bedwetting.	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 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	V 367		

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V 367	Continued From page 7 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 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;	V 367		

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V 367	Continued From page 8 (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 interviews and record reviews the facility failed to report a Level II incident to the Local Management Entity (LME) within 72 hours of becoming aware of the incident affecting 1 of 2 clients (#1). The findings are: Interview on 5/2/19 with staff #1 revealed: - On 4/24/19 client #1 walked away from the group home to the neighbor's home and the police were called. - He did not complete an incident report and did not tell the Owner or the Qualified Professional about the incident. Review on 5/2/19 of the group home's Incident Reports revealed: - No incident report was completed on 4/24/19. Review on 5/2/19 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No incident report was entered into the IRIS system about the 4/24/19 incident.	V 367		

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V 540	Continued From page 9	V 540		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on interviews and observations the facility failed to assure the right to humane care in the provision of grooming care for 1 of 2 clients audited (client # 1). The findings are: Observations of client #1's feet and hands on 5/1/19 at approximately 1:55 pm revealed: - His toenails to be overgrown. - The left foot big toe had a toenail that was 1/4 to ½ inch long. The toenail appeared to be filed to a	V 540		

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V 540	Continued From page 10 sharp point. - Observed fingernails to be trimmed. Interviews on 5/1/19 and 5/2/19 with Client #1's Legal Guardian revealed: - Observed client #1's fingernails and toenails to be long during a 4/11/19 visit. - Questioned why the Qualified Professional (QP) would cut client #1's fingernails the following day after her visit but not his toenails. - "He (client #1) was repeatedly complaining about his toenails not being cut. When I asked who was responsible for cutting [client #1's] toenails they (staff) couldn't tell me." - Was told on 4/12/19 by the Qualified Professional (QP) that he cut client #1's fingernails. - "Why did he (the QP) cut [client #1's] fingernails and not his toenails?" Interview on 5/1/19 with client #1 revealed: - He did not cut his own fingernails or toenails. - "Somebody else cuts them (fingernails and toenails)." - Could not provide the name of the person who cut his toenails/fingernails or how often. Interview on 5/2/19 with the QP revealed: - A podiatrist normally cuts all of the residents' fingernails and toenails. - He had cut client #1's fingernails himself last month. - The podiatrist was supposed to come to the group home last week and cut client #1's toenails but did not show. - Client #1's toenails had last been cut "about 1 ½ months ago."	V 540		

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V 736	Continued From page 11	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 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. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a clean manner and was not kept free from offensive odor. The findings are: Finding #1 Interviews on 5/1/19 and 5/2/19 with the Qualified Professional (QP) revealed: - Client #2's mattress was previously used by client #1 who had urinated on the mattress - Client #2's mattress had been cleaned and a vinyl mattress pad was put on it when client #1 urinated on it. - He replaced client #2's mattress later that day (5/1/19). - "Evidently that was an oversight on my part ...we replaced them (client #1 and client #2's mattresses)." Interviews on 5/1/19 and 5/2/19 with Client #1's Legal Guardian revealed: - During her 4/11/19 visit she noticed the mattress client #1 urinated on was now being used by client #2. Observations of client #2's bedroom on 5/1/19 at approximately 1:00 pm revealed: - Smelled urine odor when the Qualified	V 736		

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V 736	Continued From page 12 Professional (QP) pulled back the vinyl mattress cover on client's bed. - Light brown colored stains on the mattress Finding #2 Interview on 5/1/19 with Client #1's Legal Guardian revealed: - On 4/11/19 when she visited client #1 in the group home, "(his) mattress was soaked in urine." - During her 4/11/19 visit there were no Depends for client #1 and she was told by staff they had ordered Depends for client #1. Observations of client #1's bedroom on 5/1/19 at approximately 1:16 pm revealed: - Smelled urine odor when mattress pad was pulled back by the Qualified Professional. - Observed no vinyl mattress pad on the bed. - Observed round brown stains and light pink stains at the top of the mattress. Interviews on 5/1/19 and 5/2/19 with the QP revealed: - A month ago he had moved client #1 from the bedroom where client #2 now slept to a new bedroom with a different mattress. - He had been told a month ago by staff that client #1 was wetting the bed. - He replaced client #2's mattress later that day (5/1/19). - "Evidently that was an oversight on my part ...we replaced them (client #1 and client #2's mattresses)."	V 736		