| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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<br><br>An annual and follow up survey was completed on 6/11/2019. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. | V 000 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 112 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to develop the plan in partnership with, and obtain written consent for the plan from the legally responsible person affecting 4 of 4 audited clients (#1-4). The findings are:<br><br>Review on 6/5/2019 of client #1's record revealed:<br>- Admission date: 1/22/2014<br>- Diagnoses: Schizoaffective Disorder (D/O), bipolar type; Obesity; Hypothyroidism; Hypercholesterolemia; Hypertension; Chronic constipation; and Anemia;<br>- Client #1 had a Legal Guardian (LG) assigned by the Court;<br>- Documentation of a treatment plan dated 10/24/2018 with no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Review on 6/5/2019 of client #2's record revealed:<br>- Admission date: 1/2/2014<br>- Diagnoses: Schizoaffective D/O; Back Pain; Hyperlipidemia; and Hyperthyroidism;<br>- Client #2 had an LG assigned by the Court;<br>- Documentation of a treatment plan dated 6/25/2018 with no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Review on 6/6/2019 of client #3's record revealed:<br>- Admission date: 10/18/2016<br>- Diagnoses: Schizoaffective D/O; and Mild Intellectual Disabilities;<br>- Client #3 had a LG assigned by the Court;<br>- Documentation of a treatment plan dated | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 112 | Continued From page 2<br>10/16/2018 with no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Review on 6/5/2019 of client #4's record revealed:<br>- Admission date: 4/3/2017<br>- Diagnoses: Schizophrenia; Cannabis Use D/O, moderate, in sustained remission; and Tobacco Use D/O, severe;<br>- Client #4 had an LG assigned by the Court;<br>- Documentation of a treatment plan dated 4/9/2019 with no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Interviews on 6/5/2019 and 6/6/2019 with client #1 revealed:<br>- Client #1 could not identify any goals that had been developed for her.<br><br>Interview on 6/7/2019 with client #1's former LG (FLG) revealed:<br>- The FLG had been assigned to client #1 at the time that her treatment plan was dated;<br>- The FLG checked her notes and did not have any contact with the facility in October of 2018, therefore could not have been involved with the treatment plan development or provide consent for the plan.<br><br>Interview on 6/5/2019 with client #2 revealed:<br>- She did not know what her treatment goals were.<br><br>Interview on 6/6/2019 with client #3 revealed:<br>- Client #3 provided only short, one- or two-word answers to questions, and did not provide any information when asked about treatment goals. | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 112 | Continued From page 3<br><br>An interview attempt with clients #2 and #3's LG was made on 6/7/2019, but the LG did not return the requested call by the time of exit.<br><br>Interview on 6/5/2019 with client #4 revealed:<br>- He had unsupervised time on his treatment plan but could not identify any other treatment goals.<br><br>Interview on 6/7/2019 with client #4's LG revealed:<br>- The LG had only received treatment plan information from client #4's Assertive Community Treatment Team (ACTT) provider, not from the facility;<br>- The only treatment plan that the LG had for client #4 had expired in 2018;<br>- The LG had not participated in the development of or given consent for client #4's treatment plan relevant to the facility's services.<br><br>Interviews from 6/5/2019 to 6/11/2019 with the Qualified Professional (QP) revealed:<br>- Some LGs were difficult to reach, or did not call the QP back consistently;<br>- The QP had sent copies of the treatment plans to each client's LG, but they were not returned;<br>- The QP had been told by a Review Officer from a Local Management Entity/Managed Care Organization (LME/MCO) that as long as the QP signed the plan, the client and LG signatures were not required.<br><br>This deficiency constitutes a recited deficiency and must be corrected within 30 days. | V 112 | | |
| V 290 | 27G .5602 Supervised Living - Staff<br><br>10A NCAC 27G .5602 STAFF<br>(a) Staff-client ratios above the minimum | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 4<br>numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.<br>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.<br>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:<br>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or<br>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.<br>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:<br>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 5<br>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to document that the client was capable of remaining in the home or community without supervision affecting 4 of 4 audited clients (#1-4). The findings are:<br><br>Review on 6/11/2019 of the facility's unsupervised time sign out logs revealed:<br>- Clients #1, #2, #3 and #4 had each signed out of the facility on multiple days for varying amounts of time between 4/1/2019 to 6/11/2019.<br><br>Review on 6/5/2019 of client #1's record revealed:<br>- Admission date: 1/22/2014<br>- Diagnoses: Schizoaffective Disorder (D/O), bipolar type; Obesity; Hypothyroidism; Hypercholesterolemia; Hypertension; Chronic constipation; and Anemia;<br>- Client #1 had a Legal Guardian (LG) assigned by the Court;<br>- Documentation of a treatment plan dated 10/24/2018 with no documentation of client #1's capability to have unsupervised time or guidelines for unsupervised time;<br>- There was no documentation that an assessment of client #1's capability to have unsupervised time had been completed for the current treatment plan;<br>- There were no client or LG signatures indicating participation in development of the plan or consent to implement the plan. | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 6<br><br>Review on 6/5/2019 of client #2's record revealed:<br>- Admission date: 1/2/2014<br>- Diagnoses: Schizoaffective D/O; Back Pain; Hyperlipidemia; and Hyperthyroidism;<br>- Client #2 had an LG assigned by the Court;<br>- Documentation of a treatment plan dated 6/25/2018 with a goal related to client #2 being capable of having up to 2 hours of unsupervised time in the home or community for the next 90 days;<br>- The treatment plan had not been reviewed at the end of the 90-day period to reassess client #2's capability of having unsupervised time;<br>- There was no documentation that an assessment of client #2's capability to have unsupervised time had been completed for the current treatment plan;<br>- There were no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Review on 6/6/2019 of client #3's record revealed:<br>- Admission date: 10/18/2016<br>- Diagnoses: Schizoaffective D/O; and Mild Intellectual Disabilities;<br>- Client #3 had a LG assigned by the Court;<br>- Documentation of a treatment plan dated 10/16/2018 with no documentation of client #3's capability to have unsupervised time or guidelines for unsupervised time;<br>- There was no documentation that an assessment of client #3's capability to have unsupervised time had been completed for the current treatment plan;<br>- There were no client or LG signatures indicating participation in development of the plan or consent to implement the plan. | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 7<br><br>Review on 6/5/2019 of client #4's record revealed:<br>- Admission date: 4/3/2017<br>- Diagnoses: Schizophrenia; Cannabis Use D/O, moderate, in sustained remission; and Tobacco Use D/O, severe;<br>- Client #4 had an LG assigned by the Court;<br>- Documentation of a treatment plan dated 4/9/2019 with a goal of "[Client #4] will increase his independence by learning to manage his supervised time in the group home or unsupervised time in the community each day ..." with no guidelines or periods of time for unsupervised time specified;<br>- There was no documentation that an assessment of client #4's capability to have unsupervised time had been completed for the current treatment plan;<br>- There were no client or LG signatures indicating participation in development of the plan or consent to implement the plan.<br><br>Interview on 6/7/2019 with client #1's former LG (FLG) revealed:<br>- The FLG had been assigned to client #1 at the time that her treatment plan was dated;<br>- The FLG had talked to facility staff in the past about unsupervised time for client #1;<br>- Unsupervised time was appropriate for client #1;<br>- The FLG checked her notes and did not have any contact with the facility in October of 2018, therefore could not have been involved with the treatment plan development or provide consent for the plan.<br><br>Interview on 6/5/2019 with client #2 revealed:<br>- She did not know what her treatment goals were, but she could have unsupervised time "all day long"; | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 8<br>- Clients were required to sign out when they left the facility on unsupervised time.<br><br>Interview on 6/6/2019 with client #3 revealed:<br>- Client #3 provided only short, one- or two-word answers to questions, and did not provide any information when asked about unsupervised time.<br><br>An interview attempt with clients #2 and #3's LG was made on 6/7/2019, but the LG did not return the requested call by the time of exit.<br><br>Interview on 6/5/2019 with client #4 revealed:<br>- He had unsupervised time on his treatment plan;<br>- When he was first admitted to the facility, he was told he just had to be back in by 10:00 pm;<br>- The rules for unsupervised time were that you had to sign out when you left the facility and sign in when you returned.<br><br>Interview on 6/7/2019 with client #4's LG revealed:<br>- The LG had only received treatment plan information from client #4's Assertive Community Treatment Team (ACTT) provider, not from the facility;<br>- The only treatment plan that the LG had for client #4 had expired in 2018;<br>- When client #4 was "well", the LG was okay with client #4 having unsupervised time;<br>- The LG had not participated in the development of or given consent for client #4's treatment plan relevant to the facility's services.<br><br>Interview on 6/5/2019 with staff #1 revealed:<br>- Every client in the facility could sign out for unsupervised time;<br>- Only one client was limited to less than one hour of unsupervised time; | V 290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 290 | Continued From page 9<br>- The process for clients using unsupervised time was for them to sign out on the log sheets and tell the staff they were leaving and where they were going;<br>- If staff #1 had any concerns about a client leaving for unsupervised time, he would call the Qualified Professional (QP) to discuss the concerns.<br><br>Interviews from 6/5/2019 to 6/11/2019 with the Qualified Professional (QP) revealed:<br>- Unsupervised time assessment forms for each client were in their records, but had not been filled out because the LGs did not want to sign them;<br>- Some LGs were difficult to reach, or did not call the QP back consistently;<br>- The QP had sent copies of the treatment plans to each client's LG, but they were not returned;<br>- Each client was assessed at the time of admission regarding safety in the community while on unsupervised time;<br>- If clients were capable of having unsupervised time safely, the LG told facility staff how much time the client could have.<br><br>This deficiency constitutes a recited deficiency and must be corrected within 30 days. | V 290 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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. | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 10<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:<br><br>Observations from approximately 11:32am to 12:22pm on 6/5/2019 revealed:<br>- The kitchen counter was missing the edge laminate, was buckled at the sink, and damaged plywood was visible, making it difficult to sanitize in a food preparation area;<br>- The microwave mounted above the stove was missing the handle and had a crack in the door housing approximately 8 inches long;<br>- The dryer was located next to the stove, had a crushed dryer vent tube, the tube was not attached to the vent port to the outside, and there was lint coating the visible surface of the wall behind the dryer, creating a fire hazard;<br>- Chipped and damaged wood laminate flooring had gaps between the boards on the kitchen floor;<br>- The refrigerator had a bag of cucumbers with mold present, two small onions were resting in a reddish liquid in the door shelf;<br>- The refrigerator freezer had food crumbs on the bottom shelf, and unsealed packages of hotdogs, pizza and French fries on the shelves;<br>- A bowl with what appeared to be used cooking oil was sitting on top of the counter;<br>- The upper kitchen cabinets contained a bag of potatoes with mold present and a zipper-type baggie containing what appeared to be flour with moist, brown clumps on the flour;<br>- The cabinets had unidentified crumbs/detritus on the shelves;<br>- The under-sink cabinet had large areas of dark brown to black stains, white-colored mold, water | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 11<br>damage stains, brown stains scattered over the white drain pipes, and the bottom shelf was damaged/buckled;<br>- The Lazy Susan corner cabinet was broken, had a rusted-appearing muffin pan and soiled rag on top of the shelves, the shelves had dark stains and there was scattered unidentified crumbs/detritus throughout the shelves and cabinet;<br>- The lower stove drawer had dark stains on the top edge;<br>- The door blinds in the dining room and living room had broken slats that were hanging loose;<br>- 1 of 3 bulbs that were present in the hallway light fixture were burned out, and 1 of 4 bulbs were missing;<br>- The upstairs hallway bathroom had 3 of 5 bulbs burned out;<br>- In client #2's bedroom, a thick layer of dust was present on the window sill, ceiling, and ceiling fan blades; a piece of broken window blind fell as the blind was lowered; and there were chipped and raised areas along the seams between the laminate wood floor boards;<br>- The smoke detector in the downstairs hallway was hanging loose from the ceiling with wiring exposed;<br>- The front porch had a broken step, and the handrails were loose, creating a fall risk;<br>- The front exterior and storm doors had damaged fascia;<br>- The back deck had loose handrails and broken floor boards, creating a fall risk;<br>- The cover for the exterior electrical outlet was missing;<br>- The exterior siding was mildewed;<br>- There were patches of grass that had grown to approximately 1 ½ feet high;<br>- The cover for the sewer line cleanout was broken/missing. | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 12<br><br>Observation at approximately 1:05 pm on 6/5/2019 revealed:<br>- Client #4's bedroom had cracked ceiling plaster, the unmade box springs and mattress were resting on the floor, plastic-covered sofa and loveseats were stored in the room, and clothing was piled on the closet floor and spilled out into the bedroom itself.<br><br>Observation at approximately 1:35 pm on 6/6/2019 in client #3's bedroom revealed:<br>- A thick layer of dust was on the ceiling and the fan blades of the ceiling fan/light fixture;<br>- The laminate flooring had chips, gaps and raised areas;<br>- Two dressers were present, both with missing and loose drawer pulls/knobs;<br>- The mattress on one of two beds dipped in the middle; and<br>- The toilet in the master bathroom ran water constantly.<br><br>Observation at approximately 1:50 pm on 6/6/2019 revealed:<br>- Client #1's bedroom had an odor of urine present;<br>- The bed and multiple shopping bags piled on the floor blocked access to the windows used for secondary emergency egress;<br>- Client #1's mattress had a large dip with metal springs sticking through near the head of the bed, creating a risk for injury;<br>- The laminate flooring in the downstairs hallway was damaged;<br>- The upstairs bedroom beside client #2's bedroom had chipped laminate with gaps, and raised areas; and<br>- The doorknob was loose on the upstairs bedroom door. | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 13<br><br>Review on 6/5/2019 of the Division of Health Service Regulation (DHSR) Construction Section Biennial survey completed on 7/25/2018 revealed:<br>- The Construction Section had cited deficiencies related to emergency plans and supplies, compliance with building codes, location and exterior requirements, and facility design and equipment;<br>- Multiple issues identified during the Construction Section survey had not been resolved by the time of the current survey;<br>- Unresolved issues included: laminate flooring damage, dresser in a bedroom had missing knobs and broken drawers, kitchen counter damage, loose porch and deck handrails, front storm door damage, mildewed exterior vinyl siding, missing/burned out light bulbs, and dryer exhaust damage with loose connection to the exterior dryer vent.<br><br>Interviews on 6/5/2019 and 6/6/2019 with client #1 revealed:<br>- She did not know how long the springs had been sticking through her mattress;<br>- Her bed was uncomfortable to sleep on;<br>- She could not specify how long other repair needs in the facility had been present.<br><br>Interview on 6/5/2019 with client #2 revealed:<br>- She did not have any problems at the facility;<br>- She did not need to use the handrails at the front or back steps;<br>- She only entered and exited the facility through the back door to the deck;<br>- Client #2 provided very brief, rapid answers to questions, and did not elaborate on any topic when asked for clarification. | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 14<br><br>Interview on 6/6/2019 with client #3 revealed:<br>- He did not have any problems with the flooring, dressers, constantly running toilet, or any other maintenance or cleanliness issue at the facility;<br>- Client #3 provided only short, one- or two-word answers to questions, and did not elaborate when asked for clarification of his statements.<br><br>Interview on 6/5/2019 with client #4 revealed:<br>- " ... A lot of things can be fixed, even painting, waxing the floor ..."<br>- The facility needed a new microwave;<br>- Client #3 broke the step on the front porch;<br>- Clients did not use the front door very often;<br>- "The deck is weak, and the front porch is weak. I don't know how to fix that ..."<br><br>Interview on 6/5/2019 with staff #1 revealed:<br>- The Operational Personnel Supervisor (OPS) was the staff responsible for coordinating repairs at the facility;<br>- When facility staff discovered damages or problems with the physical condition of the facility, they were supposed to call the OPS and she would schedule the repairs;<br>- Clients and staff did not use the front door, so he was not aware the step was broken;<br>- Clients and staff entered the facility by the back deck door;<br>- Staff #1 cooked every day and did not have any problems with the appliances;<br>- Staff #1 was not aware of any other damaged areas of the facility<br>- The floors had been "done" (repaired) both upstairs and downstairs, but he could not recall when;<br><br>Interview on 6/7/2019 with the OPS revealed:<br>- The OPS was in charge of maintenance if something needed to be fixed in the facility; | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 15<br>- After the DHSR Construction Section completed the biennial inspection in July of 2018, repairs had been made at the facility;<br>- Repairs included the cabinet under the kitchen sink, bathroom flooring, and window repairs;<br>- The OPS inspected the facility approximately three times each month;<br>- The most recent inspection by the OPS was probably during the middle of May 2019;<br>- The facility had a maintenance man who worked on repairs when he got a chance to fit them in his schedule;<br>- The maintenance man had three homes he was responsible for;<br>- The OPS had already given a list of needed repairs to the maintenance man, including the broken boards on the front porch and back deck;<br>- The smoke detector hanging loose in the downstairs hallway was an oversight by the maintenance man when he was installing new smoke detectors recently;<br>- The broken front porch and back deck boards were replaced on 6/6/2019;<br>- The OPS had already been in the process of purchasing new mattresses for each of the sister facility's that the Licensee operated;<br>- A new mattress for client #1 had been ordered;<br>- A foam mattress cover was placed on client #1's bed last night to cover the springs until the new mattress was delivered;<br>- The OPS had not seen any moldy food in the facility;<br>- The direct care staff in the facility were supposed to ensure the refrigerator and cabinets were cleaned regularly.<br><br>Interviews from 6/5/2019 to 6/11/2019 with the Qualified Professional (QP) revealed:<br>- The QP had previously talked to the Landlord about repairs needed at the facility; | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 16<br><br>- The Landlord was supposed to make needed repairs by next week or the facility management was going to do the repairs themselves and take the cost of the repairs out of their rent payment;<br>- A maintenance person would be at the facility on 6/6/2019 to begin working on the porch and deck;<br>- Flooring had been replaced throughout the facility following the July 2018 DHSR construction Section biennial survey;<br>- The QP made notes and took photographs of areas to be addressed during a walkthrough with the Surveyor;<br>- The QP would ensure that identified areas of concern were cleaned and repaired.<br><br>Review on 6/6/2019 of the Plan of Protection dated 6/6/2019 written by the QP revealed:<br>- What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?<br>"Clients will be encouraged to use the back door at least for the next 48 hours in order to have deck at the front fixed. The door will be closed and staff will monitor clients closely to ensure they will not use it. The maintenance man will start work to repair deck. Also, staff will place a barrier on the deck at the back door to prevent client injuries. The kitchen counter, dryer and electrical wiring hanging will be secured."<br>- Describe your plans to make sure the above happens.<br>"Director of NOA Human Services will ensure work order is given to maintenance, Landlord or any repair company to start work immediately."<br><br>The facility had a multitude of long-standing, previously identified repair and cleanliness issues. Amongst the issues were broken and loose decking and railing boards that created fall hazards, dryer lint covering the wall near the | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-316 | A. BUILDING: _____ B. WING _____ | R 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NOA HUMAN SERVICES II, INC | 3801 PALMIRA TRAIL WINSTON SALEM, NC 27127 |

| (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 736 | Continued From page 17<br>stove that created a fire hazard, spoiled and contaminated food items that created a risk for illness if served to clients, damaged counters and cabinets in food preparation areas that could not be sanitized adequately, exposed wires on client #1's mattress that created an injury risk, and the hanging smoke detector with exposed wiring that could result in a fire detection failure. Because of the multitude of maintenance/cleanliness problems, and the severity of the damages throughout the facility, this is detrimental to the health, safety and welfare of the clients. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day. | V 736 | | |