PRINTED: 07/12/2019 FORM APPROVED

Division of Health Service Regi	ulation			FORM APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	Tama-
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
	MHL034-381	B. WING		С
NAME OF PROVIDER OR SUPPLIER				06/26/2019
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATI		
NOA HUMAN SERVICES, INC		OKESDALE AVEN		
		N SALEM, NC 271	101	
(X4) ID SUMMARY ST PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
TAG REGULATORY OR I	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE
		1,40	DEFICIENCY)	RIATE DATE
V 000 INITIAL COMMENTS		11.000		
NATIAL COMMENTS	9	V 000		
A complaint survey w	as completed on 6/26/19.			
The complaints were	substantiated (Intake#			
NC00152739 & NC00	0152733). Deficiencies were			
cited.	102/00). Deliciencies were			
This facility is licensed	for the following service		7,107, 14,111	a a ltha
category: 10A NCAC:	27G .5600A Supervised		DHSR - Mental H	eaim
Living for Adults whos	e primary diagnosis is			
Mental Illness.			JUL 18 2019	
V 108 27G .0202 (F-I) Perso	nnel Requirements	V 108	Lic. & Cert. Section	
			Lic. a Oci i. oco	CIOIS
10A NCAC 27G .0202	PERSONNEL			
REQUIREMENTS				
(a) Employee tesisis	on shall be documented.			
(g) Employee training	imum, shall consist of the			i
following:	inum, shall consist of the			
(1) general organizati	onal orientation:			
(2) training on client ri	ights and confidentiality as			1
delineated in 10A NCA	C 27C, 27D, 27E, 27F and			
10A NCAC 26B;				
(3) training to meet the	e mh/dd/sa needs of the			1
client as specified in the	e treatment/habilitation			
plan; and				
(4) training in infectiou bloodborne pathogens.				
(h) Except as permitted				1
.5602(b) of this Subcha	inter at least one stoff			
member shall be availa	ble in the facility at all			
times when a client is p	resent. That staff			
member shall be trained	d in basic first aid			
including seizure manag	gement, currently trained			
to provide cardiopulmor	nary resuscitation and			
trained in the Heimlich r	maneuver or other first aid			
techniques such as thos	se provided by Red Cross,			
the American Heart Ass				
equivalence for relieving	arway obstruction.			
(i) The governing body	snall develop and			
Service Regulation		·		

Divi

STATE FORM

TITLE

(X6) DATE

Division	of Health Service Regu	lation			FORM APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
		MHL034-381	B. WING		C 06/26/2019
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	1 00/20/2013
NOA HUN	IAN SERVICES, INC		OKESDALE AV		
		WINSTO	N SALEM, NC	27101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 108	Continued From page	1	V 108		
	reporting, investigating	d procedures for identifying, g and controlling infectious seases of personnel and			
	trained in Basic First A Resuscitation (FA & CI #1). The Findings are: Review on 6/26/19 of S - Date of Hire: 6/1/19 - High School Graduati - No documentation of - Observation on 6/25/7 am Staff #1 was the on home with Client #1, CI Client #4 present in the Interview on 6/25/19 wi - "I took it (FA &CPR) in where it is at now."	ew, observation and led to ensure that staff was id and Cardiopulmonary PR) for 1 of 3 staff (Staff Staff #1's record revealed: on date: 6/17/17 FA & CPR training 19 at approximately 9:30 ly staff present in the lient #2, Client #3 and home. th Staff #1 revealed: high school. I don't know		The Administractor we everynew Staff good To before resuming duties must be on the act new Staff Starts TAICAR Comp. Certificate on fil	0
(((27G .0209 (C) Medicati 10A NCAC 27G .0209 M REQUIREMENTS (c) Medication administr (1) Prescription or non-ponly be administered to order of a person authordrugs.	MEDICATION ration: prescription drugs shall	V 118		

MFOE11

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Division of Health Service Re	egulation				FORM APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		THE CONTRACTOR OF THE CONTRACT
- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	NOTION		DATE SURVEY
	1				OOM LETED
	MHL034-381	B. WING			С
AME OF PROVIDER OR SUPPLIER	CTDC=	DODES -			06/26/2019
OA HIIMAN CERVICATA		ADDRESS, CITY, STATE			
DA HUMAN SERVICES, INC		OKESDALE AVENU			
(X4) ID SUMMARY :	STATEMENT OF DEFICIENCIES	N SALEM, NC 271			
PREFIX (EACH DEFICIEN	NCY MUST BE DECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	RRECTION	(X5)
THE SUBATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETE
V/110 0			DEFICIENCY)		
V 118 Continued From page	ge 2	V 118			
(2) Medications sha	ll be self-administered by				
clients only when au	othorized in writing by the				
client's physician.					
(3) Medications, incl	uding injections, shall be	The second secon			
administered only by	licensed persons or by				
unicensed persons	trained by a registered nume				
pharmacist or other	legally qualified person and				
Privileged to prepare	and administer medications				
(4) A Medication Adn	ninistration Record (MAD) of				
Current Medications	ed to each client must be kept				
recorded immediately	administered shall be				
MAR is to include the	y after administration. The				
(A) client's name;	ollowing:				
(B) name, strength, a	and quantity of the drug;				
(C) instructions for ad	Iministering the drug;				
(D) date and time the	drug is administered; and	and the state of t			
(L) flame or initials of	person administering the	The state of the s			
arug.					
(5) Client requests for	medication changes or				
cnecks shall be record	ded and kent with the MAD				
ille followed up by app	pointment or consultation				
with a physician.					
	•				
		TO SERVICE STATEMENT			
This Rule is not met a	s evidenced by:				
Based on records review	ew. interviews and				
observations the facility	y failed to follow physician				
orders for 1 of 5 clients	(Client #1). The findings				i.
are:					
Review on 6/25/10 of C	Client #1's record revealed:	-	T 0 1 -		1
-Date of Admission: 8/1	/18		the certain Stre	ator u	2111
					- (1.
Diagnoses, achiznana		1	0.1.161 = 1	1 01	ik-
Anxiety Schizoarre	ctive Disorder, Bipolar and	m	onitor Closely	ta 84	raffs !
Arixiety		m m	The ecolminstration closely and house man	ta 84	reffs to

	on of Health Service Regu	lation			FURIWI APPROVE
AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		MHL034-381	B. WING		C 06/26/2019
NAME C	OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE. ZIP CODE	1 30,20,20,10
NOA H	IUMAN SERVICES, INC		OKESDALE AV		
			N SALEM, NC		
(X4) II PREFI TAG	X (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 1	that included the follow-Clozapine 100 mg - 1 8:00 pm) treatment of blank for this medication 6/5 through 6/19 Review on 6/25/19 of 5/11/19 through 5/31/19 that included the follow-Clozapine 100 mg - 1 8:00 pm). MAR was blathe following dates: 5/3 (am & pm dose) Review on 6/26/19 of Clotated 5/10/19 revealed -Weekly blood draws for refill 5/10/19. Review on 6/25/19 of the Provider/Laboratory blom 5/2019 and 6/2019 reversed - A Blood Draw was consumed and Further review failed to Client #1 for the weeks and 6/14. Review on 6/25/19 of Clotated and medication stabilization was having auditory has possible for the physician in 1 to 2 care Physician in 1 to 2	9 revealed documentation wing medication: tab twice daily (8:00 am & Schizophrenia. MAR was on on the following dates: Client #1's MAR dated for prevealed documentation wing medication: tab twice daily (8:00 am & ank for this medication on 80 (am & pm dose) & 5/31 Client #1's Physician order is prevealed on 5/3/19 The Mental Health and draws for Client #1 for ealed: Impleted on 5/3/19 The preveal blood draws for of 5/17, 5/24, 5/31, 6/7 Ilient #1's hospital by department ents revealed: Interval and the street of the street on 8/12/19 for hallucinations of the street on 8/12/19 for hal	V 118	manager will r	well to most have have belication have feb work nonter what on their ozapine adrens lers goon uleel The will e to have or Staft
	Interview on 6/25/19 with	n Client #1 revealed:		Cappiontment Le	1 docotors

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Division of Health Service Regu	lation			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
	DETTH IOTHOR NOWBER.	A. BUILDING	E	COMPLETED
	MHL034-381	B. WING		C
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE VID CODE	06/26/2019
NOA UUUAAN A		OKESDALE AVI		
NOA HUMAN SERVICES, INC		N SALEM, NC		
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION
PREFIX (EACH DEFICIENC TAG REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETE
V 118 Continued From page	4	V 118		
gotta have that Clozal funnyI don't refuse to have Interview on 6/26/19 w Client #1 revealed:	rith the family member of			
not receiving his media weeks before the hosp-Client #1's speech was were obsessively about -Talked about the FBI Investigation) was after were after him and tho -She reported to the Q Client #1 's Guardian the hospitalization that she receiving his Clozapine -Reported that Client # "very off" when she spot Interview on 6/25/19 with -"I was there that day (I admitted to the hospital to 6/12). I had worked to 6/12). I had worked to 6/12)He (Client#1) woke up and seemed ok. He loo out of the ordinary. He womputer and the Army listened to him go from delusional. Normal to tall called the Qualified Pland he came over and of medical service) -[Client #1] walked out to own."	as sluggish; his thoughts at numbers. (Federal Bureau of him and different police se around him. utalified Professional and two weeks prior to his thought he was not e. 1's thought process was oke with him. th Staff #1 revealed: 6/12/19, the day he was b. I stayed overnight (6/11 he last three days (6/10, 6) that morning (6/12/19) ked ok, but he was talking was talking about IBM He was hallucinating. I regular talking to alking in his head. For essional (QP) 6/12/19) called EMS (emergency) to the ambulance on his		treatment and all the house.	rent refuses

Division of Health Service Reg	ulation			FORM APPROVED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	CV2) DATE OUD (E)
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED
	MHL034-381	B. WING		C
	387-301	15		06/26/2019
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY,	STATE, ZIP CODE	
NOA HUMAN SERVICES, INC	4328 ST	OKESDALE A	/ENUE	
	WINSTO	N SALEM, NC	27101	
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	N arm
PREFIX (EACH DEFICIENC TAG REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
	COO IDEATH THIS INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
V/119 C	_			
V 118 Continued From page	e 5	V 118	The allow stra	1 - 1. L
(Client #1) didn't have	e medication (Clozapine). He	and the second	The adminstra	to Rend
called the pharmacy	to see what the problem		H . 1	11
was.		e de la companya de l	the house meir	rager will
-You will have to ask	him (QP). I don't know why	100	0000000 4-1	31 0 10
he didn't have medica	ation."		ensure their ell	chents
			Medicentronser	in the
Interview on 6/25/18	with the Pharmacy	in the second		
	e for Clozapine prescription	The property of the state of th	house from the f	right eley utt
fills for Client #1 reve		and the second s	DI OU	5 516 . 81 suld
a physician order and	Clozapine medication without	district the second	the month. Phens	MAKA MODIA
documentation for ea	the blood draw		be Contacted if	- enry 15
	doctor visit are important		BC CONTINUES OF	
for him (Client #1) to r			missing and to	S CUP O I
	ssed a few blood draws.	59 - 10 - 10 - 10	1	I de laceres
-The last blood draw y	we have on file for [Client		Should the unter	3111160117
#1] would be May tent	th (5/10/19).	Model Vision	any refulle from	to slactor
- We would have then	processed the order and		any refills from	LOG POCIO.
sent Clozapine medica	ation to the group home on	Application of the state of the	is decided. Me	elicentrons
	9). That prescription would		22 .1 clased. Me	SICON GIP
be for a seven-day su	ppiy. further blood draws after		Shold be called	in days
that. Therefore, we wo	and not send one		Distribe Carred	. Or early
medication.	riot seria arry	ĺ	petale knussing a	of to
	Staff) had Clozapine for him			
(Client #1) it wasn't fro	m this pharmacy.		allow time for 1	mcelly
-The next blood draw		***************************************	0 0 00	, - 00
fourteenth (6/14/19) ar	nd medication was sent."	4	and delivery.	
Interview on COFIA	201. 3.0	-		
Interview on 6/25/19 w Provider/Laboratory re				
	pine is very important and		7	10/19
requires blood draws to	have the prescription	1	\	110111
filled.	and prodottphott	4.0	0 10	
-He had refused some	blood draws (could not		Hecord form to be	2 Completell
remember dates and h	ad no documentation to			
show refusals). We wo	uldn't have documented		Should excomption	HA Cliets to
that (refusals for blood	draws). We might have		1 1 C-mataladi	0, 1
called the group home	about his refusal. We can't		Lab - Completed b.	1 Lab- Heth.
make him (Client #1) g	et his blood drawn. That is		and Signed.	7/10/10

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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: C B. WING MHL034-381 06/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4328 STOKESDALE AVENUE NOA HUMAN SERVICES, INC WINSTON SALEM, NC 27101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) V 118 V 118 Continued From page 6 not our responsibility. -Without the Clozapine you might see hallucinations, possibly manic, off balance and verbally speaks of things he may not normally speak of." Descrit form to be Completed by Lab Tech and Signed must reviewed con Clients return from Leib Interview on 6/26/19 with the QP revealed: "Staff (Staff #1) called me (6/12/19) and told me [Client #1] was not acting right and I went into the group home. I called the EMS (emergency medical service). -Prior to his (Client #1) hospitalization (6/12/19) I found out he was not given his medication work by Staff poor onduty (Clozapine). -I called the pharmacy and found out he hadn't to ensure 5100d drawne had blood draws. I called the laboratory and they said he hadn't been coming in. He is supposed to House manager will ensure go on the transit system." -QP was asked who makes sure Client #1 gets Staff accompand client to on transit system and who verifies his blood draws. QP reported "[Client #1] goes his self on all approximents. transit system." There was no answer from the QP as to who confirms his blood draws and that 7/10/19 Client #1 gets to laboratory. Review on 6/26/19 of the Plan of Protection dated 6/26/19 and written by the Qualified Professional revealed: This Plan was in effect "The facility will ensure that consumer will be monitored closely. Also, all his appointments to the lab and doctor's appointments, a staff will be 6/26/19 assigned to accompany him always. The facility will encourage consumer to abide by the doctor's orders. Staff will also ensure that administrative staff mostly the QP, will be informed when consumer reuses treatment. QP and the administrative staff will monitor papa-professional on duty to enforce consumers going to all appointments and then go with them."

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: C MHL034-381 DEFICIENCES, INC NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES WINSTON SALEM, NC 27101 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE DEFICIENCY)
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING O6/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HOA HUMAN SERVICES, INC 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NOA HUMAN SERVICES, INC 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING O6/26/2019 STREET ADDRESS, CITY, STATE, ZIP CODE 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING CROSS-REFERENCED TO THE APPROPRIATE DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NOA HUMAN SERVICES, INC 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
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NOA HUMAN SERVICES, INC 4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE)
WINSTON SALEM, NC 27101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
V 118 Continued From page 7 V 118
Client#1 is diagnosed with Schizoaffective and Bipplar Disorder. He is prescribed closening for
Bipolar Disorder. He is prescribed clozapine for
weekly blood draws for the medication Clozapine
his disturbed thinking. Client #1 was ordered weekly blood draws for the medication Clozapine to be refilled. The facility failed to have a system in place for monitoring Client #1's compliance with peeded labs and confirming that blood draws
in place for monitoring Client #1's compliance
The record and collining that blood draws
were completed. Client #1 missed 5 appointments for blood draws Staff Present-
Client #1 missed 5 appointments for blood draws and 17 days of Clozapine dosing.
Staff #1 reported observing Client #1's disturbed
thinking on 6/10, 6/11 and on 6/12. Staff #1 called
thinking on 6/10, 6/11 and on 6/12. Staff #1 called the QP to assist with Client #1's behavior. The
QP reported that on 6/12/19 you could tell
something was wrong with Client #1 and then
called EMS to have Client #1 hospitalized.
The QP gave no explanation other than Client #1
refused his blood draws as to why Client #1 missed 17 days of his antipsychotic medication
Clozapine.
This deficiency constitutes a Type A1 rule
violation for serious neglect and must be
corrected within 23 days. An administrative
penalty of \$2000.00 is imposed. If the violation is
not corrected within 23 days, an additional
administrative penalty of \$500.00 per day will be
imposed for each day the facility is out of compliance beyond the 23rd day.
compliance beyond the 25rd day.
V 133 G S 122C 80 Criminal History Days I Gl
V 133 G.S. 122C-80 Criminal History Record Check V 133
G.S. §122C-80 CRIMINAL HISTORY RECORD
CHECK REQUIRED FOR CERTAIN
APPLICANTS FOR EMPLOYMENT.
(a) Definition As used in this section, the term
"provider" applies to an area authority/county
program and any provider of mental health,
developmental disability, and substance abuse services that is licensable under Article 2 of this
our vices that is incertsable under Article 2 of this

	Division of	Health Service Regu	ılation			FO	RM APPROVE
I	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	0(0) 0 1	
I	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			TE SURVEY MPLETED
l				A. BOILDING.			VII ELILO
l			MU 024 204	P MANO		1	C
ŀ			MHL034-381	B. WING		0	6/26/2019
l	NAME OF PRO	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
l	NOA HUMA	N SERVICES, INC	4328 ST	OKESDALE AVEN	NUE		
L	TO THOMS		WINSTO	N SALEM, NC 27	7101		
	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	PECTION	
	PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETE
	IAG	TILOUDATONT ON L	SO IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF	PROPRIATE	DATE
r	1/400				DEFICIENCY)		
	V 133 (Continued From page	8	V 133			
		Chapter.					
			offer of employment by a				
	ŗ	provider licensed under	er this Chapter to an				
		applicant to fill a nositi	ion that does not require the				
	a	applicant to have an o	ccupational license is	THE STATE OF THE S			
	C	conditioned on conser	nt to a State and national	and the same of th			
	C	riminal history record	check of the applicant. If				
	ti	ne applicant has been	a resident of this State for				
	le	ess than five years th	en the offer of employment				
	is	conditioned on cons	ent to a State and national				
	С	riminal history record	check of the applicant. The				
	n	ational criminal histor	v record check shall				
	ir	clude a check of the	applicant's fingerprints. If				
	th	ne applicant has been	a resident of this State for	To the second se			
	fi	ve years or more, the	n the offer is conditioned	A Property of the Property of			
	O	n consent to a State of	criminal history record				
	cl	neck of the applicant.	A provider shall not				
	e	mploy an applicant wi	ho refuses to consent to a				
	Cr	riminal history record	check required by this				
	Sé	ection. Except as other	erwise provided in this				
	SL	ubsection, within five I	business days of making				
	th	e conditional offer of	employment, a provider				ř.
	sh	nall submit a request t	to the Department of				į.
		stice under G.S. 114			*		
	cr	iminal history record	check required by this				
	SE	ection or snall submit	a request to a private				
	er	itity to conduct a Stat	e criminal history record				
	C	eck required by this s	section. Notwithstanding				
	G.	turn the results of not	partment of Justice shall				
	re	turn the results of nat	ional criminal history				1
		cord checks for employered by Public Law	Jyment positions not	Commission of the Commission o			
	D ₂	epartment of Health a	nd Human Sandara	A CONTRACTOR OF THE CONTRACTOR			
	Or	iminal Records Check	k Unit Within five	and the state of t			M.
			t of the national criminal	enin hanne			
	hic	story of the nerson 4	e Department of Health	-			
	20	d Human Services	riminal Records Check				1
	l In	it shall notify the are	vider as to whether the				
	infe	ormation received ma	y affect the employability				
	11111		A MINOR THE CHIMINATIMIA	. 1			

Division o	f Health Service Regu	lation			FORM APPROVE	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	Way DATE OF DESCRIPTION	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
M						
		MHL034-381	B. WING		C	
NAME OF PR	OVIDER OR SUPPLIER				06/26/2019	
TO SILL OF THE	O NO EN ON SOFFEIER		DDRESS, CITY, S			
NOA HUMA	IN SERVICES, INC		OKESDALE AV			
Assistance			N SALEM, NC	27101		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO	ORRECTION (X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETE	
		•	ing	DEFICIENCY)		
V 133	Continued From page	9	V/ 422			
			V 133			
	of the applicant. In no	case shall the results of the				
	national criminal histor	ry record check be shared				
,	with the provider. Prov	riders shall make available				
	upon request verificati	on that a criminal history	and the same			
	check has been compl	leted on any staff covered	To Branch of			
	by this section. A coun	ty that has adopted an				
	he Division of Crimina	ance and has access to	1			
	may conduct on baball	Information data bank				
	may conduct on behalf	check required by this				
S	section without the pro	vider having to submit a	er en			
	equest to the Departm	nent of Justice. In such a	Para Para			
C	ase, the county shall	commence with the State				
C	riminal history record	check required by this				
s	ection within five busin	ness days of the	To make the second of the seco			
C	onditional offer of emp	ployment by the provider.			-	
A	all criminal history infor	mation received by the				
р	rovider is confidential	and may not be disclosed,				
е	xcept to the applicant	as provided in subsection				
(0	o) of this section. For p	ourposes of this	and the same of th			
S	ubsection, the term "p	rivate entity" means a	44-7-7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			
D	usiness regularly enga	aged in conducting			5	
CI	riminal history record	checks utilizing public				
	cords obtained from a					
(C	c) Action If an applica	ant's criminal history ne or more convictions of				
a	relevant offense the	provider shall consider all				
of	the following factors i	in determining whether to				
	re the applicant:	ar determining whether to	di nama			
) The level and seriou	sness of the crime.	The Public of th			
(2) The date of the crime	e.	The state of the s		1	
) The age of the person				1	
co	nviction.				1	
(4) The circumstances s	surrounding the	Triange and			
	mmission of the crime		The state of the s		-	
(5) The nexus between	the criminal conduct of	The state of the s			
the	e person and the job o	luties of the position to be				
	ed.					
(6)	The prison, jail, prob	ation, parole,				

Division o	<u>f Health Service Regu</u>	lation			(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL034-381	B. WING		C 06/26/2019
NAME OF PROVIDER OR SUPPLIER STREET A		STREET AD	DDECC CITY C	FATE ZID CODE	1 00/20/2010
			DRESS, CITY, ST		
NOA HUMA	AN SERVICES, INC		KESDALE AVI		
2441 15	CUMMACNICATI		SALEM, NC	2/101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 133	Continued From page	10	V 133		
find the position of the posit	rehabilitation, and emperson since the date (7) The subsequent of a relevant offense. The fact of conviction shall not be a bar to ellisted factors shall be offensed in the provider disqualification of the reprovider may disclose the criminal history red to the disqualification, of the criminal history red complies with this sect civil liability for: (1) The failure of the prodividual on the basis he criminal history red calcium and offenses if the history record check and criminal offenses if the history record check is compliance with this see (2) Failure to check and criminal offenses if the history record check is compliance with this see (2) Relevant Offense. Felevant offense mean ederal criminal history and compliance with the sea of the production of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the criminal history and compliance with this sea of the provide the provide the criminal history and compliance with this sea of the provide	ployment records of the the crime was committed. In the commission by the person of of a relevant offense alone imployment; however, the considered by the provider. In the considered by the provider. In the considered by the provider. In the considered by the provider in contained in cord check that is relevant but may not provide a copy record check to the A provider and an officer der that, in good faith, ion shall be immune from the contained in cord check of the individual. In the contained in cord check of the individual. In the contained in cord check of the individual. In the contained in contained in the contained in th			
ls E	ssuing Monetary Subsindangering Executive	e 5, Counterfeiting and titutes; Article 5A, and Legislative Officers; cle 7A, Rape and Other	The state of the s		

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING MHL034-381 06/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4328 STOKESDALE AVENUE** NOA HUMAN SERVICES, INC WINSTON SALEM, NC 27101 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 133 Continued From page 11 V 133 Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes. supplies, or otherwise gives false information on

an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the

	of Health Service Regu	lation			FURM APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY
			A. BUILDIN	G:	COMPLETED
		MHL034-381	B. WING _		C 06/26/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET/	ADDRESS, CITY	STATE, ZIP CODE	1 00/20/2019
NOA HUMA	AN SERVICES, INC		OKESDALE A		
NOATION	AN SERVICES, INC		N SALEM, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 133	Continued From page	12	V 133		
	prior to obtaining the a criminal history record subsection (b) of this s fingerprint cards as red (2) The provider shall s criminal history record business days after the conditional employmer	not employ an applicant applicant's consent for a check as required in section or the completed quired in G.S. 114-19.10. Submit the request for a check not later than five a individual begins at. (2000-154, s. 4; 24, ss. 10.19D(c), (h):			
B re fc -P -N ba	or 1 of 3 staff (Staff #1)	w the facility failed to ground check prior to hire). The findings are: staff #1's record revealed: staff #1's criminal the Qualified		The endminstreensure that the his conducts all bac Checks prove to conducts and even where filled.	ring Staff Keyround Staff Starting