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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED
		MHL034-334	B. WING		02/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	
NOA HIIM	AN SERVICES III, INC	1847 WA	YCROSS DRIVE		
NOA HUW	AN SERVICES III, INC	WINSTO	N SALEM, NC 271	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual survey was Deficiencies were cite	s completed on 2/16/2022. ed.			
		d for the following service 27G .5600A Supervised Mental Illness.			
	The survey sample co	onsisted of audits of 3			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transmistered persons transmistered to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for addictions of the control of	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:			

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

TITLE (X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL034-334	B. WING		02	2/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
NOA HIIM	IAN SERVICES III, INC	1847 WA	YCROSS DRIVE			
NOA HUIV	IAN SERVICES III, INC	WINSTO	N SALEM, NC 271	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 1	V 118			
	checks shall be recor	ded and kept with the MAR pointment or consultation				
	facility failed to ensur current, and administ documented immedia	as evidenced by: ews and interviews, the e that the MAR was kept ration of medications was ately following administration s (#1, #2 & #3). The findings				
	blind; Type I Diabetes - Physicians orders for - Divalproex sodium tablets QHS (every nr 9/15/2021; - Eszopiclone 1 mg, 10/1/2021; and - Lorazepam 1mg, 1	3/2015 shrenia; Deafness; Legally shrenia; Phypothyroidism or the following medications: ER 500mg (milligrams), 3 sight at bedtime), dated 1 tablet QHS, dated				
	MARs dated 12/1/202 - No documentation of following: - Divalproex on 12/31 - Eszopiclone on 2/1/					

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DIVISION	n nealth Service Negu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLE	ETED
			7 50.250.			
		MHL034-334	B. WING		02/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1847 WAY	CROSS DRIVE			
NOA HUM	AN SERVICES III, INC	WINSTON	SALEM, NC 2	7106		
			· ·			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPR		DATE
IAG	REGOLATORI GIVI	EGG IBERTII TING IN GRAMMITON)	TAG	DEFICIENCY)	.,	
				,		
V 118	Continued From page	e 2	V 118			
	1 3					
	Review on 2/11/2022	of client #2's record				
	revealed:					
	- Admission date: 4/9	/2018				
	- Diagnoses: Schizop					
	•	Pulmonary Disease (COPD)				
		` ,				
		or the following medications:				
	•	, 1 tablet QD (every day),				
	dated 10/15/2021;					
	Benztropine mesyl	ate 0.5mg, 1 tablet BID				
	(twice daily), dated 11	1/8/2021;				
		2-1/2 tablets BID, dated				
	10/15/2021;	, ,				
	·	ER 500mg, 1 tablet QD,				
	dated 10/15/2021; an					
	Haloperidol 2mg, 1	I tablet QHS, dated				
	10/15/2021.					
	Reviews on 2/10/202	2 & 2/11/2022 of client #2's				
	MARs dated 12/1/202	21 to 2/10/2022 revealed:				
	- No documentation of	of administration of the				
	following:					
	Atorvastatin on 1/3	30/2022 & 1/31/2022				
		ate at 8:00AM on 1/31/2022;				
	and at 8:00PM on 12					
		· · · · · · · · · · · · · · · · · · ·				
	1/30/2022 & 1/31/202	,				
		AM on 1/31/2022; and at				
	8:00PM on 1/30/2022	2, 1/31/20222 &				
	2/1/2022-2/9/2022;					
	Divalproex sodium	on 1/31/2022; and				
	Haloperidol on 1/3					
	Review on 2/11/2022	of client #3's record				
	revealed:	5. 55.10 // 0 5 10001d				
		2/2015				
	- Admission date: 11/	_,				
		ual Disability, Moderate;				
	Persistent Depressive	e Disorder; Hyperlipidemia;				
	Hepatitis C; CAD (cor	ronary artery disease);				
	"Verbal Fracture"; Imp					
		or the following medications:				
	,		1	I		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING: COMPL	
		MHL034-334	B. WING		02/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		1847 WA	CROSS DRIVE		
NOA HUM	AN SERVICES III, INC	WINSTON	SALEM, NC 2	7106	
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	CTION (X5)
PREFIX TAG	(EACH DEFICIENC)	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	2 3	V 118		
	Alendronate sodium dated 9/9/2021; Sertraline HCL (hy tablets QAM, dated 9/9/2021 tablet QD, dated 9/9/2/2 - Multivitamin with m 9/9/2021. Review on 2/10/2022 MARs dated 12/1/202/2 - No documentation of following: - Alendronate during 1/16/2022-1/31/2022; - Sertraline HCL on 1/2021;	drochloride) 100mg, 2 /9/2021; U (international units), 1 2021; and ninerals, 1 tablet QD, dated & 2/11/2022 of client #3's 21 to 2/10/2022 revealed: of administration of the			
	- Multivitamin with min MARs dated 12/1/202	nerals was not listed on the 21 to 2/10/2022.			
		2 with client #1 revealed: at medicines he took, but he lay.			
		22 with client #2 revealed: I been administered by every day.			
	 He did not know what taking. He could not clearly missed any medication Interview on 2/11/202 She had administered medications correctly 	2 with Staff #1 revealed: ed client #1, #2 and #3's			

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- She would immediately make sure she

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			D. WING	a www		
		MHL034-334	B. WING		02/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NOA HUM	AN SERVICES III, INC		CROSS DRIVE SALEM, NC 2	7106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPI DEFICIENCY)	BE COMPLE	ETE
V 118	Continued From page	e 4	V 118			
	corrected any errors of MARs.	with documentation of the				
	- He did not review M that there were not m them.	22 with the HM revealed: ARs himself, but he thought any mistakes made with assional (QP) dealt with any ications.				
	 Clients' MARs were Pharmacies. He believed that Clie administered all of the He was not aware o of medication administration 	ents #1, #2 and #3 had been eir medications correctly. f the missing documentation				
V 736	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it maintained in a safe,	EMENTS	V 736			
		n and interviews, the facility n a safe, clean, attractive The findings are:				

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STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MUU 004 004	B. WING		00/40/0000	
		MHL034-334			02/16/2022	4
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1847 WAY	CROSS DRIVE			
NOA HUM	IAN SERVICES III, INC		SALEM, NC 2			
0(0)15	STIMMADV ST			PROVIDER'S PLAN OF CORRECTION	J 0/5)	_
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-1-)	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
V 736	Continued From page		V 736			٦
V 730			V 730			
		ity and its grounds revealed:				
		top was heavily scratched				
		f bulging top veneer near the				
	sink and stove;					
	- The oven door was					
		food splatters on the inside;				
		w blind in the dining area				
	were broken;					
		netal chairs at the dining				
	table was missing the					
		inted areas of drywall				
		nches) round and 6"x5" were				
	on the living room wa					
	- In Client #3's bedroo					
		eiling fan/light fixture were				
	missing;					
	- In the half-bathroom					
		peeling above the doorway				
	and above the sink at					
		approximately 4"x4" were				
	missing bedside the o					
	- The left side bracket					
		even with the missing tiles;				
	- The vinyl flooring wa					
		om the sink drainpipes;				
	- A floor stand-type to					
	corrosion stains and b					
	- In Client #2's bedroo					
	-	oproximately 3"x2" on the				
	door on the hallway s					
	- Windows were dusty					
		ceiling fan/light fixture was				
	very dim and flickered					
	- In Client #1's bedroo					
		were present on the window;				
	- One window blind di	id not have means to raise it;				
	- There were holes or	n both sides of the door:				
	approximately 1'(foot))x1' on inside and				
	approximately 1'x8" o	on outside				
	- In the full bathroom:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. MINO			
		MHL034-334	B. WING		02/16/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
NOA HUMAN SERVICES III, INC			YCROSS DRIVE			
	WINSTO			7106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	Έ
V 736	Continued From page	e 6	V 736			
	plastic water control k - There were scattere - There were broken v between the tiles; - The wall-mounted to broken; - A wall-mounted ven - In the basement, the scattered water stains - On the exterior carp - There was a broken stained plastic bucket - There were black sta carport ceiling; - A flat tire was propp - A toilet was stored of	ed stains on the ceiling; vinyl floor tiles with gaps bilet paper holder was t was rusted; e drop-type ceiling tiles had s; ort: lawn chair beside a heavily t containing cigarette butts; ains over the entirety of the				
	American Sign Languran He was unable to id be completed at the fathe side while smiling questions. Interview on 2/10/202 - The light bulb in his needed to be replace - He did not notice replace in the house. Interview on 2/10/202 - His speech was disj	22 with Client #2 revealed: ceiling fan/light fixture				
	Interview on 2/11/202	2 with staff #1 revealed:				

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- She did not know how long the kitchen

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL034-334	B. WING		02/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NOA HIIM	IAN SERVICES III, INC	1847 WAYO	CROSS DRIVE			
NOA HOM	AN OLIVIOLO III, INO	WINSTON	SALEM, NC 2	7106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page	e 7	V 736			
	countertop had been - She did not know wh painting or other remote the facility The mildew in the bate but it came right back - The oven had been the door would not co - The House Manage in the facility. Interview on 2/16/202 - The facility building company, so some re before they could be - The rental company repair of the kitchen of bathrooms No remodeling had facility since he was h - Facility staff had use remove stains in the literature.	damaged. nen the last time any odeling was completed at athroom had been cleaned, cleaned, but the stains on ome off. r (HM) coordinated repairs 22 with the HM revealed: was owned by a rental epairs needed their approval completed. would have to approve counter and flooring in the been completed at the nired (on 7/24/2019). ed cleaning products to try to oathrooms. en any painting had been				
	HM completed a work the building owner. - The Licensee had a could complete some - He had just recently kitchen counter after trip out of the country - He would ensure the completed for the kitce - The bathrooms had	needed in the facility, the corder request and sent it to cocess to a handyman who of the work in the facility. Inoticed the condition of the returning from an extended at a work order was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
	MHL034-334	B. WING		02	16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NOA HUMAN SERVICES III, INC		CROSS DRIVE SALEM, NC 2	7106		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
a repair in the staff bath completed approximate	the carport had been from hroom that had just been	V 736			

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