STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		MHL034-381	B. WING		01/16/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NOALIII	AN 0550//050 INO	4328 STOR	ESDALE AVE	NUE		
NOA HUM	AN SERVICES, INC	WINSTON	SALEM, NC 2	7101		
(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			
	A complaint was completed on 1/16/25. The complaint was substantiated (intake #NC224912). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
		d for 4 and has a current rey sample consisted of ents				
V 111	27G .0205 (A-B) Assessment/Treatme	nt/Habilitation Plan	V 111			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN  (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:					
	<ul><li>(1) the client's prese</li><li>(2) the client's needs</li></ul>	s and strengths;				
	established diagnosis	admitting diagnosis with an determined within 30 days that a client admitted to a				
	detoxification or other shall have an establis admission;	<sup>-</sup> 24-hour medical program shed diagnosis upon				
	(4) a pertinent socia and	l, family, and medical history;				
		sessments, such as e abuse, medical, and riate to the client's needs.				
		e provided prior to the				
	establishment and im					
	treatment/habilitation	or service plan, hereafter				
	referred to as the "pla	n," strategies to address the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	(X3) DATE SURVEY COMPLETED	
		A. BOILDING			
		MHL034-381	B. WING		01/16/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
NAME OF T	NOVIDEN ON 3011 EIEN		OKESDALE AVEN		
NOA HUM	AN SERVICES, INC		N SALEM, NC 27		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE
V 111	11 Continued From page 1		V 111		
	client's presenting pro	oblem shall be documented.			
	facility failed to ensure	iew and interviews, the e an assessment was			
	completed prior to the affecting 2 of 3 audite findings are:	e delivery of services and clients (#1 and #4). The			
	Review on 1/16/25 of - Admission date: 4/1	client #1's record revealed: 3/17			
		hrenia; Schizoaffective e; and Anti-Social Personality			
		ssion assessment in his			
	Review on 1/16/25 of - Admission date: 11/	client #4's record revealed:			
	· ·	ffective Disorder, Bipolar			
	Туре				
	- There was no admis record.	sion assessment in his			
	Manager revealed:	and 1/16/25 with the House			
		ssional (QP) was out of the			
	country and he was fi - He was not the staff	lling in for the QP.  who usually kept up with			

Division of Health Service Regulation

STATE FORM 6899 0DKI11 If continuation sheet 2 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL034-381	B. WING		0.	C 1 <b>/16/2025</b>
	PROVIDER OR SUPPLIER	4328 ST	ADDRESS, CITY, STATE	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	DN SALEM, NC 271  ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 111	the admission assess  Attempted interview of the country.  Attempted interview of the country.		V 111			
V 738	27G .0303(d) Pest Co 10A NCAC 27G .030 EXTERIOR REQUIR (d) Buildings shall be rodents.	3 LOCATION AND	V 738			
	facility was not kept findings are:  Review on 1/16/25 of - Admission date: 4/1 - Diagnoses: Schizop Disorder Bipolar Type Disorder  Review on 1/16/25 of - Admission date: 12/ - Schizophrenia and li	ew and interviews, the ree from insects. The  f client #1's record revealed: 3/17 shrenia; Schizoaffective e; and Anti-Social Personality  f client #2's record revealed: 19/24 Bipolar  f client #4's record revealed:				

Division of Health Service Regulation

STATE FORM 6899 0DKI11 If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. DUILDING: _				
		MHL034-381	B. WING		C 01/16/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
NOA HUM	AN SERVICES, INC	4328 STC	KESDALE AVE	NUE		
			N SALEM, NC 2			
(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 738	Continued From page	e 3	V 738			
	- Diagnoses: Schizoaffective Disorder, Bipolar Type - There was no admission assessment in his file.  Interview on 1/14/25 with client #1 revealed: - In the past couple of months, he had seen bed bugs on the walls in his bedroom.					
	<ul><li>Had recently seen b</li><li>Does not know how been in the facility.</li></ul>	with client #2 revealed: led bugs in his bedroom. long the bed bugs have s heat it (the facility) up as that will kill them (bed				
	Interview on 1/15/25 v - "I don't know about	with client #4 revealed: the bed bugs."				
	Interview on 1/14/25 with staff #1 revealed: - Her only job was to clean the facility She had heard there were bed bugs in the facility but was unable to provide any more details.					
		with staff #4 revealed: ere any bed bugs in the				
		with staff #5 revealed: ere any bed bugs in the				
	Attempted interview on 1/24/25 with the Qualified Professional (QP):  - Unable to interview QP as he was currently out of the country.  Attempted interview on 1/16/25 with the Licensee:  - Left a voicemail message and she did not return					

Division of Health Service Regulation

STATE FORM 6899 0DKI11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25		С	
MHL034-381		B. WING	<del></del>	01/16/2025		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	-	
		4328 STO	KESDALE AVEI	NUE		
NOA HUM	AN SERVICES, INC	WINSTON	SALEM, NC 2	7101		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 738	Continued From page	e 4	V 738			
	the call.					
	Manager revealed: - He was filling in for the country In April 2024 the factorial local exterminator treschemical First reported after the local exterminator bugs "until now." - Then he reported afteratment by the local still some bed bugs sthe exterminator said He had learned from this past Friday (1/10) in the facility. The Supthis from staff #1 One 1/14/25, he pla who previously treate let the exterminator kinds bug infestation.	the QP while he was out of ility had bed bugs and the ated the bed bugs with a he April 2024 treatment by he did not see any bed ter the April 2024 bed bug exterminator, "there were een after the treatment but that was to be expected." In the Supervisor in Charge (25) that they had bed bugs pervisor in Charge learned onned to call the exterminator d the facility for bed bugs to now about the current bed				
		the facility and only did				
	facility had bed bugs.	r told her yesterday the				
	Office Employee reve	with the Local Exterminator's caled: eated the facility for bed dates: 4/4/23, 10/17/23 and				

Division of Health Service Regulation

- On 5/9/24 they did a follow up phone call with

STATE FORM 6899 0DKI11 If continuation sheet 5 of 6

PRINTED: 01/20/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED				
						<u> </u>			
		MHL034-381	B. WING			6/2025			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
NOA HUM	AN SERVICES, INC		ESDALE AVE						
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE	(X5) COMPLETE DATE			
V 738	the House Manager a activity" reported after company did not send check for bed bugs af	and learned there was "no r the 4/18/24 treatment. Her d an exterminator back to fter the 4/18/24 treatment. ot heard from any staff at	V 738						

Division of Health Service Regulation

STATE FORM 6899 0DKI11 If continuation sheet 6 of 6