STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 5/28/25. The complaints were unsubstantiated (intake # NC00229312 and intake # NC00229413). Deficiencies were cited. This facility is licensed for the following service category: 10 A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 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: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter	V 111	RECEIVED JUN 16 2025 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richmond Okoe TITLE: MS, QMHP (X6) DATE: 6/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 111	Continued From page 1 referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to complete an assessment prior to the delivery of services for 1 of 3 audited clients (#3). The findings are: Review on 5/20/25 of client #3's record revealed: - An admission date of 3/15/23 - A diagnosis of Schizophrenia - An assessment had been completed by facility staff on 3/15/23 which detailed client #3's presenting problems as a need for housing and medication management - No other documentation which reflected client #3's other needs and strengths; pertinent social, family and medical history etc. Interview on 5/20/25 with the Qualified Professional revealed: - "I need to get my files (client records) organized." This deficiency is a re-cite deficiency and must be corrected within 30 days.	V 111	QP will ensure moving forward an assessment will be completed prior to admission/ start of needs, Problems, strengths	6/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	Continued From page 2	V 513		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services using the least restrictive and most appropriate methods affecting 3 of 3 audited clients (#1, #2 and #3). The findings are: Observation on 5/20/25 at 9:13 am of a kitchen cabinet revealed:	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	Continued From page 3 - A silver padlock on a cabinet where canned goods and other food items were kept - The Supervisor In Charge (SIC) used a key to unlock the lock on the cabinet door Review on 5/20/25 of client #1's record revealed: - An admission date of 8/1/11 - Diagnoses of Schizophrenia with Bipolar; Hyperlipidemia; Hypertension; and Gastroesophageal Reflux Disorder (D/O) - No documentation in client #1's record which reflected that based on client #1's behavior, the use of a restrictive intervention (a keyed lock on a kitchen cabinet door) was necessary Interview on 5/20/25 with client #1 revealed: - A lock had been placed on the cabinet because a former client (Deceased Client #4 (DC #4) would take food from the kitchen without staff permission - "We (clients) aren't allowed to go into the cabinets because she (the SIC) fixes and cooks everything." Review on 5/20/25 of client #2's record revealed: - An admission date of 10/22/10 - A diagnosis of Schizoaffective D/O, Bipolar Type - No documentation in client #2's record which reflected that based on client #2's behavior, the use of a restrictive intervention (a keyed lock on a kitchen cabinet door) was necessary Interview on 5/20/25 with client #2 revealed: - No concerns reported regarding the lock on the kitchen cabinet door Review on 5/20/25 of client #3's record revealed: - An admission date of 3/15/23 - A diagnosis of Schizophrenia	V 513	HM/SIC will ensure ALL Locks to be ~~rem~~ removed from Cabinets moving forward.	6/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	Continued From page 4 - No documentation in client #3's record which reflected that based on client #3's behavior, the use of a restrictive intervention (a keyed lock on a kitchen cabinet door) was necessary Client #3 was unable to be interviewed on 5/20/25 due to his arguing with unknown person(s) (who were not present) in the facility whom he believed had taken his money and other belongings Interview on 5/20/25 with the Supervisor In Charge (SIC) revealed: - She kept the key to the kitchen cabinet on her person - "We used to have a client (DC #4) that would go into the cabinet to get bread and canned soups." - She no longer resided in the facility due to her death on 9/27/24 of cardiac arrest - "It's just a habit for me to lock it." Interview on 5/20/25 with the Qualified Professional revealed: - Confirmation the lock had been placed on the cabinet door to addressed DC #4's behavior of taking food from the kitchen without staff permission	V 513	HM/SIC ensured lock is removed-	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers,	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 5 employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 6 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 7 to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 8 as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 staff (staff #1, the Supervisor In Charge (SIC) and the Qualified Professional (QP)) completed annual training on alternatives to restrictive interventions. The findings are: Review on 5/16/25 of staff #1's record revealed: - A hire date of 10/24/24 - A job description of Paraprofessional - A certificate which reflected staff #1 had received training in "NCI Plus, Prevention and Crisis Training" on 10/22/25 - The certificate was signed by the "Presenter" and listed their title as "PharmD. (Pharmacist)." Review on 5/16/25 of the SIC's record revealed: - A hire date of 5/15/13 - A job description of Paraprofessional - A certificate which reflected staff #2 had received training in "NCI Plus, Prevention and Crisis Training" on 3/3/25 - The certificate was signed by the "Presenter" and listed their title as "PharmD." Review on 5/16/25 of the QP's record revealed: - A hire date of 2/27/16 - A job description of QP - A certificate which reflected the QP had	V 536	NOA will ensure that all staff records including NCI+ needs to be updated by Certified trainer.	6/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 9 received training in "NCI Plus, Prevention and Crisis Training" on 3/3/25 - The certificate was signed by the "Presenter" and listed their title as "PharmD." Review on 5/16/25 on a North Carolina Department of Health and Human Services (NC DHHS) website which listed individuals who were approved to instruct others in NCI techniques in the state of NC revealed: - No evidence the "Presenter" listed on staff (#1, #2 or the QP's) certificates was a trained NCI instructor An email sent on 5/16/25 at 10:14 am to an individual with the NCI Plus program requested confirmation that the "Presenter" listed on the staff (#1, #2 and the QP's) certificates was a certified NCI instructor. The individual responded at 1:45 pm via email with the following: "I'm not showing [name of the "Presenter"] an NCI Plus Instructor." Interviews on 5/16/25 with staff #1; the SIC and the QP revealed: - All had been trained by the individual listed as the "Presenter" on their NCI certificates Interviews on 5/16/25 and on 5/20/25 with the QP revealed: - There was no response when told the individual the facility used to train their staff in NCI was not on a list of state approved NCI instructors (5/16/25) - The facility staff only used de-escalation techniques and did not engage in the use of physical restraints (5/16/25) - He would request the individual that the facility used to train their staff in NCI send a copy of his instructor's certificate certificate to the	V 536	Agency will use certified trainer moving forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-271	A. BUILDING: _____ B. WING _____	R-C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4420 EDREM AVENUE WINSTON-SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 10 Division of Health Service Regulation's (DHSR's) office via fax (5/20/25) On 5/22/25, a second request to the QP to provide a copy of the instructor's training certificate. The QP reported that the individual was not in his office on 5/22/25 and that "he (the instructor) will get back to you (the DHSR surveyor)..." Interview on 5/28/25 with the QP revealed: - Did not realize the instructor used by their facility to train staff in NCI had not yet provided an instructor's certificate to the surveyor(s) per his request - Would have to consider finding another instructor if this individual could not provide him with evidence of his being a certified instructor As of the close of the survey on 5/28/25, no instructor's certificate was made available for review.	V 536		