	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 . 2	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		MHL034-334	B. WING		R-C 05/28/2025	
	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	TATE, ZIP CODE		
		1847 WAY	CROSS DRIN			
NOA HUI	VIAN SERVICES III, IN	C	SALEM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COI	(X5) MPLE DATE
V 000	INITIAL COMMENT	S	V 000			
	on 5/28/25. The co	ow up survey was completed mplaints were substantiated 07 and intake #NC00229408). ited.				
		ed for the following service C 27G .5600A Supervised Mental Illness.				
		ed for 6 and has a current irvey sample consisted of lients.				
V 115	27G .0208 Client Se	rvices	V 115			
	<ul> <li>(a) Facilities that pro- assure that:</li> <li>(1) space and super the safety and welfait</li> <li>(2) activities are suitain and treatment/habilities served; and</li> <li>(3) clients participate activities.</li> </ul>	able for the ages, interests, ation needs of the clients in planning or determining				
	in these Rules as "24 available 24 hours a unless otherwise spe (c) Facilities that sen	ams designated or described 4-hour" shall make services day, every day in the year. ecified in the rule. /e or prepare meals for hat the meals are nutritious.		PEOPlys		
		have a physical handicap		RECEIVED		
	are transported, the with secure adaptive	vehicle shall be equipped		JUN 16 2025		
( r ii t	e) When two or mor equire special assist n a vehicle are trans here shall be one ad	e preschool children who ance with boarding or riding ported in the same vehicle, ult, other than the driver, to		DHSR-MH Licensure Se	ct	
ion of Hea	Assist in supervision					
PATORY	RECTOR'S OR PROVIDER		TURE	TITLE	(X6) DAT	E

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If continuation sheet 1 of 21

Division	of Health Service R	equiation			FORM	APPROVE
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		PLETED
					F	R-C
		MHL034-334	B. WING			28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
	MAN SEDVICES III IN	1847 WA	YCROSS DI	RIVE		
NOA HUI	MAN SERVICES III, IN	WINSTO	SALEM, N	IC 27106		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
				DEFICIENCY)	t ter tr he	
V 115	Continued From pa	ae 1	V 115			
		30 .				
					٨	eld-e
				NOA has a menu a Staffs will Continue to	and	6/9/25
	This Rule is not me	t as evidenced by:		NOA has a mana		
	Based on observation	on, review and interview, the		Q (12 will Chartmup to	2	
	facility failed to ensu	ire that meals that were		Staffs will a Crave		
	served and/or prepa	red for the clients were		prepare and Dun	010	
	nutritious. The finding			Staffs will Continue To Prepare and Serve What is on the me to Clients at all t in Clients Snacks.	AA CP	
				to charte at all t	TIMES	
	Observation on 5/14	/25 of the facility's kitchen		lo cheus o		
	area at 9:15 am reve			in Clience Snacks.		
		e staff (staff #1) present in				
	the facility			10		
	<ul> <li>Staff #1 was fryin</li> </ul>	ng a pot of diced potatoes				
	- Stall #1 distribut	ed a bowl of potatoes to each				
	client with no other fo	bod offered/provided				
	Observation of the fa	cility's refrigerator and pantry				
	between 9.47 am an	d 10:05 am revealed:				
		and an opened package of				
1	bologna	an opened package of				
		chup, mustard, salad				
(		auce etc) on the shelves in				
t	he refrigerator					
-	The freezer secti	on of the refrigerator held		/		
f	rozen items which in	cluded the following: opened		1		
t	bags of crinkle french	fries; chicken nuggets;				
t	ater tots; fish fillets; a	a frozen chicken patty;				
S	sausage patties; two	packages of bologna; five				
Ĩ	ankiurters; 2 frozen	pizzas; three or four frozen				
p	bickon parts course	determined number of				
C	incken parts covered	d in freezer burn in an		(		
u	Indated zippered plas	suc bag		( ] )		
h	utter: and unonened	n opened jar of peanut jar of grape jelly; one		$\mathbb{V}$		
	th Service Regulation	Jar of grape jelly; one				

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If continuation sheet 2 of 21

D	IVI	ision	of	Health	Service	Regulation
-		and the second se			Adventional state of the second s	the second s

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
	MHL034-334	B. WING			-C 28/2025
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		OT RE O RE O
OA HUMAN SERVICES III, IN	C 1847 WAY	CROSS DR	IVE		
	WINSTON	SALEM, NO	C 27106		
REFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLET DATE
Loops); a 33 oz boy than one half of a b cereal; one package drink mix; one quar two unopened bags container of oatmea servings); two cans one can (15.25 oz.) of green beans; two beans; one can (10. packages of ramen Review on 5/14/25 Daily Menu" menu p revealed: - Meals were liste - 5/14/25 was a V - Breakfast on We "Oatmeal, Applesau was to be "2 Grilled (Sandwich), Chips, H be "Chicken Nugget (Vegetable), SL (Slice Aid." Interview on 5/14/25 - Was provided th - "We are lacking used to not be that w awhile now, like one - Potato chips and snacks when availab - "I ain't had the m [client#3] does. I thin pizza because we rai	2 ounce (oz.)) of cereal (Fruit of tutti fruitti cereal and less ag (39.5 oz.) of frosted flake e of strawberry single serve er of a bag of potato chips; of potato chips; one sixth of a l (approximately two (15.50 oz.) of pinto beans; of corn; one can (14.50 oz.) cans (15 oz.) of pork and 5 oz.) hot dog chili; and six noodles of a "NOA Human Service osted on the kitchen wall d for each day of the week /ednesday ednesdays was was to be ce, Toast and Coffee; Lunch CH (Cheese) Sand cool Aid and Dinner was to s (8), FF (French Fries), Veg ed) Bread (optional) Kool with client #1 revealed: ree meals a day some groceries right now, it ay, it's been that way for or two years." cookies were provided as le oney to buy food, but c last week he bought us all	V 115	NOA will Continue Serve food as Sta On to memu on HM] TL will or grocener are to Orelevel and deliquered and the grocene Stor Contracted to Supply needed food Hems for the foerlity.	rel 2848 Deine Deine bry	6 4 3

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If continuation sheet 3 of 21

STATEMEN	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TI	PLE CONSTRUCTION	(VOLDATT	01105170
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		G:	(X3) DATE COMP	SURVEY
		MHL034-334	B. WING		R- 05/2	C 8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE		
NOA HUI	MAN SERVICES III, IN	1847 WA	CROSS DE	RIVE		
		WINSTOI	SALEM, N	IC 27106		
(X4) ID PREFIX	SUMMARY STA (EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE OPRIATE	COMPLETE DATE
V 115	Continued From pa	ge 3	V 115	Stall will Cas	trang	
	hamburgers."			DIST WIN CO.	throug	
	- Food was purch reimbursed."	nased by staff, and "they get		to prepare for	e les	
		potatoes for breakfast and		int about 30	S.J.	
	"nothing else."	produce for broadlast and		wow mend ha	Steel	
	<ul> <li>When asked if I</li> </ul>	ne were hungry, client #2				
	was still hungry)	e eaten more" (because he				
		eat lunch, I do sometimes, I'm				
	trying to lose weight					
one o		ave potato chips for snack or				
	one or two cookies."					
		esh fruit available to the ave applesauce sometimes,				
	If we don't have ann	lesauce, I go without."				
		soup for dinner on 5/13/25				
1	out was not sure					
1	nterview on 5/14/25	with client #3 revealed:				
-	He had hot dogs	for dinner on 5/13/25 and				
	otatoes for breakfa:	st the morning of 5/14/25				
-	nimself and his hous	bizza and Chinese food for				
-		nes, maybe three."				
-	"We should all ea	at something. If I eat, I want				
n	ny friends to eat."					
-	Had not purchas	ed any food for himself or his				
-	ousemates in March	s to the HS who reimbursed				
h	im for the food purch	hases				
Ir	nterview on 5/14/25	with staff #1 revealed:				
-	Six adult male cli	ents resided at the facility				
-	Groceries were d	elivered to the facility from a				
1"	big box/supercenter			/		
w	eeks, the fifteenth o	ies) were delivered every 2 f each month and the last				
di	ay of the month."			(All and a second s		
-		nenu which was posted on		×1/		
and the second s	e wall at the facility			$\setminus V$		
on of Healt	h Service Regulation					

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If continuation sheet 4 of 21

	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF C	ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COMPLETED	
		MHL034-334	B. WING		R-C 05/28/2025	
NAME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	05/26/2025	
		1047 14/45	CROSS DR			
NOA HUMAN	SERVICES III, IN		SALEM, N			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLE	
- need - (sta (GH- the bit o grou - lack stree food deliv - time clien rece - u purc in th - u shou care - H siste - 5/15 what - T nood - T - T nood - T - T nood - T - T - T - T - T - T - T - T - T - T	id to change it up When the facilit (ff) usually call [th (IM)] but he is ou [House Supervise of groceries or th up." When he had sp of food in the face sed out over the l and says we have very (grocery) or He had purchas is over the past y ots's meals; how ipts for those put One some occas hased food for he e facility 'Neither one of u about mine (mo Had submitted a r facility]" on 5/1. We may get gro 5/25), when groce we have." We must wait for re running low, s rent items of foo Planned to prepa les for the clients That's all we rea Clients were prove sauce for snack lo fresh fruits we las spoken to up for the clients to for the clients to	me menu for months and they p a bit." y ran low on groceries, "We he Group Home Manager t of work now. Now we call sor (HS)], they will buy a little ney will call in a pizza for the poken with the GHM about the acility, "He usually gets e food and orders a little bit of ave to wait until the next he will order us pizza." ed food "approximately ten year and a half" for the ever, he had not saved the irchases sions, client #1 had himself and the other clients us has ever been repaid, they im his money back. I don't oney)." grocery list to "[staff at a 4/25 ceries by tomorrow night eries run low we just use or groceries to be delivered if so I will use several things od) to make meals." ire packages of ramen is for their lunch lly got right now." vided cookies, or chips or	V 115	MOA WILLENS Meny Hems C Updated as n ©	ure Reded	

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If continuation sheet 5 of 21

STATEME	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		MHL034-334	B. WING			R-C
			1		05/	28/2025
VAIME OF I	PROVIDER OR SUPPLIER	Ser F T Standard F F Mar		STATE, ZIP CODE		
NOA HU	MAN SERVICES III, II	NC .	CROSS DRI			
(¥4) 15	CUBABADY CT		SALEM, NC			-
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5 COMPL DAT
V 115	Continued From pa	age 5	V 115			
	staff for taking food	r management) tries to blame I out of the house, they don't d there are six men here."				
	<ul> <li>Staff #1 prepar</li> </ul>	4/25 at 12:04 pm revealed: ed packages of ramen clients present in the facility				
	<ul> <li>Whoever was of list to the GHM or to when it was due</li> <li>Groceries were first and fifteenth of</li> <li>If a facility bega items, staff were to sister facility</li> <li>The client at the had regular healthy which make them here</li> <li>There had been</li> </ul>	n to run low on some food contact the same staff at the e facility "were good eaters, appetites, all take medicines ungry." times when the GHM or the				
	had run low on food Interview on 5/14/25	ility were notified the facility but "nothing happened." with the HS revealed: should be coming today				
	Groceries were [local big box/super "Staff gives mea	delivered to the facility from center store]." a list of the needed items and remaining. There is a certain				
a t -	amount of food for e he number of clients	ach facility and it is based on				
- t	Staff had a menu nowever, they could chose to	u they were to follow; switch up the menu if they				
	If a facility ran lot staff) call and let the Ith Service Regulation	w on groceries, "they (the administration				

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If continuation sheet 6 of 21

14/35

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG:		E SURVEY
		MHL034-334	B. WING		F	R-C 28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	, STATE, ZIP CODE		2012020
		4047 1444	YCROSS DI			
NOA HU	MAN SERVICES III, I	NC	SALEM, N			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	<ul> <li>(management) kno</li> <li>Administration out of food comple</li> <li>"The list of groupoint. Some staff rewe buy a little bit of until the groceries of orders pizza."</li> <li>No staff or client to her they had to b pockets</li> <li>Her current rolet the GHM gets "better Interview on 5/28/28 Professional revealed</li> <li>The GHM was negotiated by grocery orders on b following up on the set of the GHM had a complete the ordering box/supercenter]."</li> <li>When the GHM recently, no one had hospitalization and w GHM used</li> <li>Not sure if no or computer had impace when the GHM was "When the head t trickles down."</li> <li>It is the respons to ensure the GHM was</li> <li>"We have men the</li> </ul>	ow." would never let the facility run tely st be cruel." ceries must be sent right on equest food two days early, so food then to hold them over can be delivered or the staff ints had ever made statements buy food out of their own e was "just to help out" while er." 5 with the Qualified ed: responsible for submitting the ehalf of each facility and status of the orders a laptop computer he used to ing from "[big went into the hospital d advised him of the where the laptop was that the he having access to this cted the ordering of the food in the hospital l is not there, to get this done, ibility of the staff in the facility was aware of what food was hat eat, they really eat, want ird portions and they	V 115	HMTL er wir ensure that the Coordinate for Orders to en proper delive from the grou Store, to ewi store, to ewi store	el item surp er y zer y	6 (64/3

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If continuation sheet 7 of 21

Division	of	Health	Service	Regulation

	and octaice in					
TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
	UNE O LION	IDENTIFICATION NUMBER:	A. BUILDING:			IPLETED
		MHL034-334	B. WING			2012025
	ER OR SUPPLIER				1 05/	28/2025
	ER ON OUT FLER			STATE, ZIP CODE		
DA HUMAN S	ERVICES III, IN		YCROSS DRI			
VAND	CUMMACV CTA		N SALEM, NC	27106		
X4) ID PREFIX ( TAG R	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(×5) COMPLE DATE
V 118 Conti	nued From pag	ge 7	V 118			
V 118 27G	0209 (C) Medi	ication Requirements	V 118			
REQU (c) Ma (1) Pr only b order drugs (2) Ma clients client (3) Ma admin unlice pharm privile (4) A M all dru curren record MAR is (A) clie (B) nat (C) ins (D) dat (E) nat drug. (5) Clie checks file follo	JIREMENTS edication admin escription or ne e administered of a person au edications shall s only when au s physician. edications, inclu istered only by nsed persons t acist or other I ged to prepare dedication Adm gs administere t. Medications ed immediately s to include the ent's name; me, strength, a tructions for ac e and time the me or initials of shall be record	on-prescription drugs shall d to a client on the written ithorized by law to prescribe I be self-administered by thorized in writing by the uding injections, shall be r licensed persons, or by trained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-334	B. WING		R-C 05/28/2025	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	00	20/2025
	MAN SERVICES III. II	1847 144	YCROSS DRI			
IOA NU	MAN SERVICES III, II	WINSTOI	SALEM, NC	27106		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(×5) COMPLI DATE
V 118	Continued From pa	age 8	V 118			
	interview, the facilit Medication Adminis drugs administered current with medica immediately after a	eview, observation and y failed to ensure the stration Record (MAR) of all to each client was kept ations administered recorded dministration affecting 2 of 3 ent #2 and #3). The findings				
	- An admission d	of client #2's record revealed: late of 6/7/23 chizophrenia, Paranoid Type				-
	medications reveale - Guanfacine 2 m PO daily (8 am); Ato cholesterol) 1 tab Po (treat hypertension) Glipizide 5 mg (treat twice a day (8 am an (treat movement dis	ng (treat hypertension) 1 tab brvastatin 40 mg (treat high O daily (8 am); Lisinopril 5 mg 1 tab PO daily (8 am); t high blood sugar) 1 tab PO nd 8 pm); Benztropine 1 mg orders) 1 tab PO twice a day; 0 mg (treat Type II diabetes) 1				
	<ul> <li>- 5/14/25 revealed:</li> <li>No documentation the following medical Guanfacine 2 mg 1 the following statistics of the following medical for the following medical for the following medical for the following statistics of the following medical for the following medical for the following medical for the following statistics of the following statistics of the following medical for the f</li></ul>	of client #2's MAR from 5/6/25 on that client #2 had received tions on the following dates: ab PO daily (8 am) 5/11/25- 40 mg 1 tab PO daily (8 am) nopril 5 mg 1 tab PO daily (8 ; Glipizide 5 mg 1 tab PO nd 8 pm) 5/11/25-5/14/25; tab PO twice a day (8 am and 25 (8 am) and 5/6/25-5/13/25 CL 1000 mg 1 tab PO twice a) 5/11/25-5/14/25 (8 am) and m)				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-334	B. WING			R-C / <b>28/2025</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NOA HU	MAN SERVICES III, IN		YCROSS DRI			
(X4) ID	SUBMAADY CTA		N SALEM, NC			
PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(×5) COMPLET DATE
V 118	Continued From page	ge 9	V 118			
	<ul> <li>An admission da</li> <li>Diagnoses of Pa</li> <li>Diabetes Mellitus, Tr</li> <li>Hypertension; HIV (i</li> <li>Virus) and Hyperlipid</li> <li>Observation on 5/14</li> <li>medications revealed</li> <li>Folic Acid (support (tablet) PO (taken by C (assists with the all 1 tab PO daily (8 am diabetes) 10 mg 1 ta</li> <li>(treat Type II diabete day with meals (8 am Sodium (treat seizure bedtime (8 pm); Atom cholesterol) 1 tab PO Trazodone (depressioned)</li> </ul>	aranoid Schizophrenia; ype II; Essential Human Immunodeficiency demia /25 at 11:08 of client #3's d: ort cell growth) 800 mg 1 tab / mouth) daily (8 am); Vitamin bsorption of calcium) 500 mg ); Jardiance (Type II b PO daily (8 am); Metformin s) 500 mg 1 tab PO twice a n and 8 pm); Divalproex es) 500 mg 3 tab PO at vastatin (treat high 0 at bedtime (8 pm); on and/or sleep aid) 100 mg (8 pm); and Biktarvy (treat				
f f ( c F t t 5 0 Ir r e - -	<ul> <li>5/14/25 revealed: No documentatio administered the follo ollowing dates: Folic 8 am) on 5/14/25; Vit laily (8 am) on 5/14/25 O daily (8 am) on 5/14/25 ab PO twice a day (8 5/14/25 and Biktarvy 2 in 5/14/25</li> <li>hterviews on 5/14/25 evealed: Staff administered</li> </ul>	client #3's MAR from 5/6/25 n that client #1 had been wing medications on the Acid 800 mg 1 tab PO daily tamin C 500 mg 1 tab PO (5; Jardiance 10 mg 1 tab 14/25; Metformin 500 mg 1 am and 8 pm) at 8 am on 25 mg 1 tab PO daily (8 am) with clients (#2 and #3) their medications to them sed any doses of their				

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	of Health Service R	legulation			FORM	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL034-334	B. WING			₹-C 28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	1 001	20/2025
NOA HU	MAN SERVICES III, IN	40.171.000	AYCROSS DRI			
	Y	WINSTO	N SALEM, NO	27106		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 10	V 118			
V 536	<ul> <li>When shown bistated "I was in a huinitialed some of the initialed some of the Observation on 5/14/revealed:</li> <li>While sitting at this initials in the blat #2's) May 2025 MAR</li> <li>Interview on 5/14/25 revealed:</li> <li>When shown the Home Supervisor state we have. I can't belief</li> <li>This deficiency constant must be corrected</li> <li>27E .0107 Client Rig Int.</li> <li>10A NCAC 27E .010</li> <li>ALTERNATIVES TO INTERVENTIONS</li> <li>(a) Facilities shall important to providing disabilities, staff incluemployees, students demonstrate complete for crivinch the likelihood or stricting training in other strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the likelihood or strictione in the strategies for crivinch the strategies fo</li></ul>	<ul> <li>with the Home Supervisor</li> <li>e blanks on the MARs, the ated, "He's (staff #1] the best eve it (blanks on the MARs)."</li> <li>titutes a re-cited deficiency ed within 30 days.</li> <li>thts - Training on Alt to Rest.</li> <li>7 TRAINING ON RESTRICTIVE</li> <li>plement policies and size the use of alternatives tions.</li> <li>services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in f imminent danger of abuse with disabilities or others or</li> </ul>	V 536			

Division of Health Service Regulation STATE FORM

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If continuation sheet 11 of 21

Division	of Health Service R	egulation			1 OR	VIAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	the second second second second	E CONSTRUCTION		TE SURVEY MPLETED
		MHL034-334	8. WING		1 20076	R-C / <b>28/2025</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		1947 WAY	CROSS DRI			
NOAHUW	IAN SERVICES III, IN		SALEM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
() () () () () () () () () () () () () (	based on state com compliance and der gathered. (d) The training shal include measurable measurable testing behavior) on those of methods to determin course. e) Formal refreshe by each service provannually). f) Content of the tra- brovider wishes to en he Division of MH/D Paragraph (g) of this g) Staff shall demot collowing core areas: 1) knowledge eople being served; 2) recognizing ehavior; 3) recognizing sternal stressors that isabilities; 4) strategies fe elationships with per b) recognizing sisting in the perso ecisions about their () skills in assisting behavior; and de-escalating pot	es shall establish training petencies, monitor for internal nonstrate they acted on data Il be competency-based, learning objectives, (written and by observation of objectives and measurable ne passing or failing the r training must be completed vider periodically (minimum aining that the service mploy must be approved by D/SAS pursuant to Rule. Instrate competence in the and understanding of the g and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and that may affect people with the importance of and n's involvement in making	V 536			

Division of Health Service Regulation STATE FORM

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Division of Health Servi STATEMENT OF DEFICIENCIES	1	VIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DA1	E SURVEY
AND PLAN OF CORRECTION		ITIFICATION NUMBER:			COM	NPLETED
	MI	HL034-334	B. WING		10 months	R-C /28/2025
NAME OF PROVIDER OR SUPP	LIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE		
		1847 WA	YCROSS DRIN	/E		
NOA HUMAN SERVICES	II, INC	WINSTO	N SALEM, NC	27106		
		F DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
		PRECEDED BY FULL YING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 536 Continued Fro	n page 12		V 536			
means for peo activities which behaviors which obehaviors which (h) Service pro- documentation at least three y (1) Docu (A) who p outcomes (pas (B) when (C) instru- (2) The D review/request (i) Instructor Q Requirements: (1) Traine by scoring 100 aimed at prevened for restric (2) Traine by scoring a pa instructor trainin (3) The tr competency-ba objectives, mea observation of tr measurable me failing the course (4) The c service provider approved by the to Subparagrap (5) Accep shall include bur (A) unders (B) metho	ele with disab directly opport are unsafe) viders shall r of initial and ears. nentation sha articipated in s/fail); and where th ctor's name; ivision of MH his document alifications a rs shall demo on testing in ting, reducing ive intervention rs shall demo sing grade of g program. aining shall b sed, include r surable testing ehavior) on the hods to deter plans to emp Division of M a (i)(5) of this able instructor are not limited tanding the a	naintain refresher training for all include: the training and the ney attended; and I/DD/SAS may tation at any time. and Training onstrate competence in a training program g and eliminating the ons. onstrate competence in testing in an e measurable learning ing (written and by hose objectives and rmine passing or instructor training the oloy shall be IH/DD/SAS pursuant Rule. or training programs ed to presentation of: dult learner; ing content of the				

Division of Health Servic STATE FORM

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If continuation sheet 13 of 21

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334		E CONSTRUCTION	CON	E SURVEY IPLETED R-C 28/2025
			1		1 000	2012020
AME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
	MAN SERVICES III, IN	IC.	CROSS DRIV			
104 110	mrat oeterioeo m, m	WINSTON	I SALEM, NC	27106		
(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 CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(x5) COMPLE DATE
V 536	performance; and (D) document (6) Trainers s teaching a training reducing and elimin interventions at leas review by the coach (7) Trainers s aimed at preventing need for restrictive annually. (8) Trainers s instructor training at (j) Service provider documentation of in training for at least f (1) Docum (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Division request and review (k) Qualifications of (1) Coaches s the course which is (3) Coaches s competence by com-	tation procedures. shall have coached experience program aimed at preventing, nating the need for restrictive st one time, with positive n. shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher t least every two years. s shall maintain itial and refresher instructor three years. nentation shall include: ipated in the training and the ); where attended; and s name. on of MH/DD/SAS may this documentation any time. f Coaches: shall meet all preparation rainer. shall teach at least three times being coached. shall demonstrate upletion of coaching or	V 536			

	of Health Service R				FORM APPR	OVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:	(X3) DATE SURVE COMPLETED	
		MHL034-334	B. WING		R-C	06
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY	STATE, ZIP CODE	05/28/202	.5
		1947 14/4	YCROSS DF			
NOA HU	MAN SERVICES III, II		N SALEM, N			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMP	K5) PLET ATE
V 536	Continued From pa	ige 14	V 536			
	failed to ensure 3 or the Qualified Profes	et as evidenced by: view and interview, the facility f 3 staff (staff #1, staff #2 and ssional (QP)) completed Iternatives to restrictive		NOA will moving forward ensure a Certificed NC trainer will be Contrated to tr	e 6/4	{z
	interventions. The fi Review on 5/16/25 ( - A hire date of 1( - A job description - A certificate wh received training in ' Crisis Training'' on 1 - The certificate w	ndings are: of staff #1's record revealed: 0/24/24 n of Paraprofessional ich reflected staff #1 had 'NCI Plus, Prevention and		trainer will be Contrated to tr Stats.	ein	
	<ul> <li>A hire date of 3/4</li> <li>A job description</li> <li>A certificate whice received training in " Crisis Training" on 3/4</li> </ul>	of Paraprofessional ch reflected staff #2 had NCI Plus, Prevention and /3/25 as signed by the "Presenter"				
	A hire date of 2/2 A job description A certificate whic received training in "I Crisis Training" on 3/	of QP h reflected the QP had NCI Plus, Prevention and 3/25 as signed by the "Presenter"				
		n a North Carolina and Human Services (NC n listed individuals who were				

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PRINTED: 05/30/2025

SMMEMENT OF DEFICIENCIES MOD PLAN DE CORRENT         (N) PREVIDENCIAN DESTRICATION NUMBER MELLOSA 334         (N) PREVIDENCIAN DESTRICATION MELLOSA 334         (N) PREVIDENCIAN DESTRICATION MELLOSA 334         (N) PREVIDENCIAN DESTRICATION MELLOSA 334         (N) PREVIDENCIAN DESTRICATION MELLOSA 344         (N) PREVIDENCIANA DESTRICATION MELLOSA 344 <th(n) previdenciana<br="">DESTRICATION MELLOSA 344        &lt;</th(n)>	Divisio	n of Health Service R	egulation			FORM APPROVED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STATE, 2P CODE       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STATE, 2P CODE       NOA HUMAN SERVICES III, INC     1847 WAYCROSS DRIVE       WINSTON SALEM, NC 27106     SUMMARY STATEMENT OF DEPRCIENCES       PROVIDER OR SUPPLIER     SUMMARY STATEMENT OF DEPRCIENCES       SUMMARY STATEMENT OF DEPRCIENCES     PROVIDER PLAN OF CONTROLOUR STATEMENT OF THE APPROPRIATE       PROVIDER OF STATEMENT OF DEPRCIENCES     PROVIDER PLAN OF CONTROLOUR STATEMENT OF THE APPROPRIATE       OFFICE     A providence the Presenter' listed on staff     V 536       An email sent on 5/16/25 at 10:14 am to an Individual the OP's certificates was a certified NCI Instructor. The Individual responded at 1:45 pm via email with the following: 'Tm not should be trained NCI Instructor's CITIE APPROPRIATE     Staffes G NOCH OF       Interview on 5/16/25 aw th staff #1 revealed:     - She had been trained in NCI Instructor's CITIE APPROPRIATE OF     Staffes G NOCH OF       Interview on 6/16/25 am on Si20/25 with staff #1 revealed:     - The facility staff only used de-esca			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
STREET ADDRESS. CITY. STATE. 2P CODE       1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106       CONTINUE OF DEPENDENCES INVESTON SALEM, NC 27106       DEPENDENCES III, INC       INVESTOR SEALER OF DEPENDENCES INVESTON SALEM, NC 27106       DEPENDENCES III, INC       DEPENDENCE       DEPENDENCES III, INC       DEPENDENCES III, INC       DEPENDENCE       DEPENDENCE       DEPENDENCE       DEPENDENCE       DEPENDENCE       DEPENDENCE       DEPENDENCES			MHL034-334	B. WING		
1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106       PAGEN     Converting and the provided statement of the mean and	NAME O	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	
(X4)D TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST & EFRECEDED BY PLL REGULATORY OR LSC DENTIFYING INFORMATION)     0 PREFIX TAG     PROVERSE ALL OCCORRECTIVE ALL OD CORRECTIVE CROSS-REFERENCE DE OT THE APPROPRIATE DEFICIENCY       V 536     Continued From page 15 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     V 536     NOULT'S for Quark tech instruction the staff (#1, #2 or the QP's) certificates was a trained NCI instructor     V 536     NOULT'S for Quark tech instruction the staff (#1, #2 and 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."     NOCH of NCT :       Interview on 5/15/25 with staff #1 revealed: - There was no response when told the individual the facility used to train their staff in NCI was not on 1 list of state approved NCI instructors (016/25)     NOCH of Provision of Health Service Regulation's (DHSR's) office via fax (5/20/25)       On 5/22/25, a second request the individual was not in his office on 5/22/25 and that "he (the instructor) will get back to you (the DHSR surveyor)"	NOA H	JMAN SERVICES III, IN	C 1847 WAY	CROSS DE	RIVE	
<ul> <li>approved to instruct others in NCI techniques in the state of NC revealed:</li> <li>No evidence the "Presenter" listed on staff (#1, #2 or the QP's) certificates was a trained NCI instructor</li> <li>An email sent on 5/16/25 at 10:14 am to an individual 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."</li> <li>Interview on 5/15/25 with staff #1 revealed:</li> <li>She had been trained in NCI</li> <li>Interviews on 5/16/25 and on 5/20/25 with the QP revealed:</li> <li>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)</li> <li>The facility used to train the staff in NCI was not on a list of state approved NCI instructors (5/16/25)</li> <li>The facility used to train their staff in NCI was not on a list of state approved NCI instructors (5/16/25)</li> <li>The facility used to train their staff in NCI was not on a list of state approved NCI instructors (5/16/25)</li> <li>The facility used to train their staff in NCI was not no his office on 5/22/25 and that the facility used to rain their staff in NCI was not on a list of state approved NCI instructors (DHSR's) office via fax (5/20/25)</li> <li>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)"</li> </ul>	PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
		approved to instruct the state of NC reve - No evidence the (#1, #2 or the QP's) instructor An email sent on 5/1 individual with the Ni confirmation that the staff (#1, #2 and the certified NCI instruct at 1:45 pm via email showing [name of the Instructor." Interview on 5/15/25 - She had been tra Interviews on 5/16/25 revealed: - There was no res individual the facility of was not on a list of st (5/16/25) - The facility staff of techniques and did no physical restraints (5/ - He would request facility used to train th of his instructor's cert Division of Health Ser office via fax (5/20/25) On 5/22/25, a second provide a copy of the in certificate. The QP re was not in his office on instructor) will get bac surveyor)"	others in NCI techniques in valed: Presenter" listed on staff certificates was a trained NCI 6/25 at 10:14 am to an CI Plus program requested "Presenter" listed on the QP's) certificates was a or. The individual responded with the following: "I'm not e "Presenter"] an NCI Plus with staff #1 revealed: ained in NCI 5 and on 5/20/25 with the QP sponse when told the used to train their staff in NCI ate approved NCI instructors only used de-escalation of engage in the use of 16/25) the individual that the peir staff in NCI send a copy ificate certificate to the vice Regulation's (DHSR's) ) request to the QP to instructor's training ported that the individual in 5/22/25 and that "he (the	V 536	Mains forward ( Will Ensured The Certifical NCI treaner will be Contracted to t	reen

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If continuation sheet 16 of 21

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		E SURVEY
and a state of the state of the		MHL034-334	B. WING			R-C /28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DORESS. CITY	STATE, ZIP CODE	1 00	2012025
	MAN SERVICES III II	1047 14(4)	YCROSS DF			
NOA HU	MAN SERVICES III, I	WINSTO	N SALEM, N	C 27106		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
	Interview on 5/28/2 - Did not realize facility to train staff an instructor's certif his request - Would have to instructor if this indi with evidence of his As of the close of th instructor's certificat review. 27G .0303(c) Facilit 10A NCAC 27G .030 EXTERIOR REQUII (c) Each facility and maintained in a safe manner and shall be odor. This Rule is not me Based on observatio and its grounds were	5 with the QP revealed: the instructor used by their in NCI had not yet provided ficate to the surveyor(s) per consider finding another vidual could not provide him being a certified instructor the survey on 5/28/25, no te was made available for y and Grounds Maintenance 03 LOCATION AND REMENTS its grounds shall be p, clean, attractive and orderly a kept free from offensive	V 536 V 736	HM/TL WILL en their Mainteunce	nsure dept.	6/7/2
	are: Observation of the fa 8:52 am and 2 pm re	acility on 5/14/25 between evealed:		that Maintainer Will Keep 4p - Burrounding of facility as requ	tte tte	
	<ul> <li>Debris (dead lea the facility</li> <li>The carport did r light fixture</li> <li>The screen in the</li> </ul>	r: the roof of the facility ves and limbs) on the roof of not have a light cover on the e carport door was broken ette butts scattered about				

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Division	of Health Service Re	egulation			FORMA	APPROVE
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE S COMPL	
		MHL034-334	B. WING		R-(	C 3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY	, STATE, ZIP CODE	00/20	12023
NOA HU	MAN SERVICES III, IN	4.00 4.00 4.444	CROSS DE			
		WINSTON	SALEM, N	IC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	Continued From pay and covering the gro the front door of the Kitchen/Dining Roor - A heating/air cor - Rust speckled s - Wooden kitchen Upstairs Bathroom ( - Black spots on the - Missing towel ba - Overhead exhau - Dust and unknow holder - Chipped floor tile color - Sealant around the color - Sealant around the color - Shower tiles were and grout around the Client bedrooms #1, i Black scuff marks walls - No sheet on client appeared to be balled he bed Mattress is dirty ( lark in color) - Cobwebs were in dients' bedroom wind iving room: Worn and stained	ge 17 bund near the steps leading to facility n: nditioning vent covered in rust ide of the refrigerator chair with torn seat covering for client and staff use): he ceiling over the shower in st fan covered in dust wn film on the toothbrush es and tiles which differed in he base of the toilet was e discolored with soap scum shower was black in color #2 and #3: s around the beds on the it #2's bed; bedding i up along with clothing on white mattress which is now the windowsills of all the	V 736		el 1 - all be teel	G (HZ)
-	A chair with a soile eather-like) seat Worn flooring insid	ed cloth back and a torn de the front door as in between the front door				

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If continuation sheet 18 of 21

Division	of Health Service R	egulation			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		MHL034-334	B. WING		R-C 05/28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
		1847 WAY	CROSS DR	IVE	
NOA HU	MAN SERVICES III, IN	WINSTON	SALEM, N	C 27106	An end of the second
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 736	Continued From pa	hade -	V 736	HM/TL/ Meuntain dept will ensure	ce 6/4/25
	and the screen doo	r		dept will ensure	
	Hallway:				
		in two different areas to bulb in the light fixture in the		a work	0
	hallway			a work-order 1 Completed and within the time f required.	fixed
	Basement stairs:			within the time	Tame
	- Carpet on the s	tairs leading to the basement		2000 1000	
	was soiled and fray	ed		required	
		door is taped all the way			
		er of the door and cannot be ing the tape off from around			
	<ul> <li>The staff current located upstairs</li> <li>The downstairs construction" and w</li> </ul>	5 with staff #1 revealed: htly used the client's bathroom or staff bathroom was "under vas unable to be used coilet "stops up and a whole			
	<ul> <li>There was a "P staff who visited the</li> <li>One of the PCS complete household housekeeping tasks</li> <li>Believed the "statement of the statement of the</li></ul>	staff's responsibilities was to datasks which included			
	- Had been out o - When asked at the facility, staff #2 need to be replaced Interview on 5/14/25	f order for "two months." bout the overall condition of stated, "Whole lotta things			
vision of H	revealed: ealth Service Regulation			V V	
TATE FORM		e e e e e e e e e e e e e e e e e e e	<sup>3899</sup> E	BXFS11	f continuation sheet 19 of 21

STATE FORM

	of Health Service R				1 ORI	APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
		MHL034-334	B. WING			R-C 28/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	MAN SERVICES III. IN	1847 WA	YCROSS DRI	VE		
IOA HUI	MAN SERVICES III, II	WINSTO	N SALEM, NC	27106		
(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 CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
V 736	Continued From pa	ige 19	V 736			
	<ul> <li>not know his name</li> <li>He was respon</li> </ul>	a maintenance man she did sible for making repairs to the				
	recent visit to the fa	SR construction had made a icility the better houses."				
	with cleanliness of t addressed - The issue with t by the staff had bee - It was his under repairs were needed - Would address downstairs bathroor however, in the mea					
		stitutes a re-cited deficiency ed within 30 days.				
	EQUIPMENT (b) Safety: Each faci constructed and equ	04 FACILITY DESIGN AND lity shall be designed, lipped in a manner that l safety of clients, staff and	∨ 744			
	This Rule is not met	as evidenced by:				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE COMF	SURVEY
		MHL034-334	B. WING			-C 8/2025
	PROVIDER OR SUPPLIER	CTDEET A	DORESS CITY	STATE, ZIP CODE		
AME OF I	-ROMDER OR SUFFLIER		YCROSS DR			
IOA HUI	WAN SERVICES III, II	NC	N SALEM, N			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 744	Continued From pa	age 20	V 744			
	Based on observat failed to ensure the manner that ensure	ion and interview, the facility a facility was equipped in a ed the physical safety of sitors. The findings are:				1-0
	Observation on 5/1 bedroom revealed:	4/25 at 11:42 am of client #3's		HM/TL Les rei heated and adu	rened	2[-28]
	- A black electric wall	space heater plugged into the		heated and adu	ised	
	<ul> <li>Although the he wall, it was not turn</li> </ul>	eater was plugged into the ed on		to prohibition a space hearte	J.	
	Interview on 5/14/2	5 with client #3 revealed:			~ m	
	<ul> <li>He had been us while."</li> </ul>	sing the space heater for "a		the facility		
	<ul> <li>Not aware that in his room</li> </ul>	5 with the QP revealed: client #1 had a space heater e space heater removed from mediately			•	
on of Hea	Ith Service Regulation		1			