STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 August 18, 2025. The complaint was substantiated (intake #NC00232871). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 4 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .5602 (V290). Based on record review and interview, the facility failed to ensure 4 of 4 clients (Client #1, #2, #3 and #4) were assessed for their capability to have unsupervised time in the facility and community. Review on 8/8/25 of the QP's personnel record revealed: -A hire date of 2/27/16. Interviews on 8/7/25 and 8/12/25 with the QP revealed: -8/7/25, his duties included working with the clients, guardians and treatment teams in developing client treatment plans and completing client assessments for unsupervised time. -No unsupervised time in Client #1's treatment	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 109	Continued From page 2	V 109		

plan.
-"I have spoke to the guardian (Client #1's private agency guardian) ... and she has not signed for unsupervised time. (The) legal guardian has to approve unsupervised time. If (guardian) don't approve, there is no unsupervised time."
-8/12/25, Client #1's 2/18/25 assessment for unsupervised time was based on his (QP)'s observation of Client #1's ability to call from a telephone, call his mother for transportation, ask for help when he needed help, and return to the facility when he walked out in the community and to the store.
-He had not completed Clients #2's assessment for his capability to remain unsupervised in the facility and community.
-"I have not reviewed [Client #3]'s assessment since his arrest (9/13/24)."
-There was no assessment for Client #4 to have unsupervised time in the facility and community.
-"I cannot tell you how often they (Clients #1, #2, and #3) sign out (of the facility). There's a sign out sheet there (at facility) ..."
-Client #4 did not go into the community.
-He was not aware Client #4's signature was on the sign out sheet.

Review on 8/15/25 of a Plan of Protection completed and dated 8/15/25 by the Administrator revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Effective August 15, 2025, NOA (Licensee) will initiate contact with the legal guardians of Clients #1, #2, #3 and #4 to discuss the immediate action plan regarding community hours/Access for qualifying individuals.
-As of this date, all clients are deemed ineligible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 109	Continued From page 3	V 109		

for community hours. Guardians and clients will be informed that client exit is now contingent upon approval from the legal guardian, effective immediately.
-All staff have been instructed that no client may exit the property without explicit authorization, beginning August 15, 2025.

Describe your plans to make sure the above happens.
-Staff Communication Protocol
-To support staff in maintaining clear and respectful communication with clients, NOA will provide talking points designed to reduce potential tension, examples include:
1. 'I understand you would like to go to the store. Please hold on while I contact your guardian for authorization.'
2. 'We have a scheduled outing at 2:00 today. You will be able to safely exit the facility at that time.'
3. 'Please provide a list of your needs, and we will purchase the items on your behalf.'
-Action #2-Unauthorized Exits
-If a client exits the property without proper authorization and does not comply with the provided alternatives:
-NOA will contact the [police department], if approved by the Legal Guardian (Action Plan #1)
-If the client returns before [police department] intervention, the call will be canceled, and an internal incident report will be completed and shared with the guardian.
-If [police department] action is taken, NOA will notify the guardian and submit an IRIS (Incident Response Improvement System) report accordingly."

Review on 8/15/25 of an amended Plan of Protection completed and dated 8/15/25 by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 109	Continued From page 4 Administrator revealed: -The beginning date for the immediate actions was identified as of August 15, 2025. -The Staff Communication Protocol was dated August 15, 2025 and moved under the immediate actions section of the protection plan. -The section "Describe your plans to make sure the above happens" had "the licensee director" changed to "Administrator "and "will monitor the QP and staff to ensure the above actions are carried out by discussions with the QP and staff on a weekly basis." This facility serves 4 clients with mental health diagnoses which include Schizophrenia, Schizoaffective Disorder and Depression. Clients #1, #2, #3 and #4 had unsupervised time in the community, but failed to have assessments which determined each of their capabilities to have unsupervised time in the facility and community. There was no reassessment of 2 clients' (Clients #2 and #3)abilities on an annual basis or as their capabilities changed. Client #3's capability to have unsupervised time in the community was not reassessed after his 9/13/24 arrest for indecent exposure and registration as a sex offender. Client #4 was not assessed for unsupervised time but was allowed to walk unsupervised in the community. Client #4's signature on the sign out sheets occurred 27 times within a 3 month period. Assessment and reassessment for unsupervised time were the responsibility of the Qualified Professional but were not completed, updated and not included in each client's treatment plan. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 5	V 115		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide supervision to ensure the safety and welfare of the clients. The findings are:	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 6 Review on 8/7/25 of Client #1's record revealed: -Admission date of 11/17/23. -Diagnoses of Schizoaffective Disorder and Bipolar Disorder. -11/20/24, a treatment goal to learn and abide by the rules and regulations of the group home and reduce episodes of any disruptive behaviors less than 3 times per week. Review on 8/12/25 of an Emergency Medical Services' (EMS) dispatch report for the period from 1/9/25 to 7/31/25 revealed: -Client #1 had 8 calls (1/9/25, 3/10/25, 4/7/25, 4/22/25, 6/28/25, 7/6/25, and twice on 7/31/25) to EMS for response which led him to be transported by EMS to a hospital. -6 of the 8 calls were for Acute Pharyngitis and shortness of breath. -In 7 out of 8 EMS responses to the facility for Client #1, there was no documentation of interactions between EMS and staff. Review on 8/5/25 of a Missing Person's Report from a local law enforcement agency for Client #1 revealed: -Client #1's name, date of birth, physical description, and photograph. -Date, time and location of occurrence was 7/31/25 at 10:00 PM near a hospital. -Additional information included that Client #1 reportedly spoke with his mother on the previous day and told her he was on a named highway "somewhere." -No known source as to who filed the report. Review on 8/6/25 of a handwritten and signed statement by Staff #1 dated 7/31/25 for Client #1 revealed: -Staff #1 came into work the morning of 7/31/25	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 7	V 115		

and when he awakened the unnamed clients up for their breakfast and medications, he discovered Client #1 was not in the facility.
-The unnamed clients told Staff #1 that Client #1 called an ambulance during the night of 7/30/25 and left the facility.
-In the evening on 7/31/25, Client #1's mother called and said Client #1 called her to pick him up from a main road near 2 local hospitals, and he (Staff #1) thought the mother was picking up Client #1 from his location.

Interview on 8/7/25 with Staff #1 revealed:
-When he arrived on morning shift on 7/31/25 and did not find Client #1 in his room, Clients #2, #3 and #4 told him Client #1 called for an ambulance around 1:00 AM on 7/31/25, then went outside, got inside the ambulance and left.
-He informed the Qualified Professional (QP) Client #1 left the facility by ambulance the night before.
-He was not working when Client #1 returned to the facility.
-"[Client #1] calls the ambulance a lot, calls them (EMS) like a cab. He will make up something and before you know it, he has called the ambulance."

Interview on 8/5/25 with Client #1 revealed:
-He called EMS twice on 7/31/25.
-"I was at [1st hospital] earlier that day and came back here (to facility). I called EMS during the night and they took me to [2nd hospital]. I stayed 1 night."
-He did not know if Staff #1, who was on duty on 7/31/25, was aware he called EMS because Client #1 met the EMS responders outside the facility.
-He called his mother from the hospital to take him back to the facility. His mother or the police usually transported him from the hospital to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 8	V 115		

facility.
-"I call EMS when I'm hurting, they take me to the hospital. They give me a shot for inflammation."
-He had a history of throat cancer.

Interview on 8/5/25 with Client #1's guardian revealed:
-Client #1 received guardianship services from a private guardianship agency.
-She was Client #1's guardian representative.
-She called the facility on 7/31/25 to talk with Client #1 to see how he was doing and learned from Staff #1 that Client #1 called EMS for himself during the night and was transported by EMS to a hospital.
-Staff #1 did not know whether Client #1 had returned to the facility until he checked Client #1's room and told her he was not at the facility.
-Her call to the QP led the facility to notify law enforcement and file a Missing person's report.
-On 8/1/25, she contacted the QP and learned Client #1 had not returned to the facility, her calls to hospitals did not result in locating Client #1, and on 8/4/25, a text message she received into the guardian's crisis line revealed Client #1's mother was picking Client #1 up from the hospital and returning him to the facility.
-Client #1 was not supposed to have contact with his mother.

Interview on 8/11/25 with the Assistant Chief of EMS revealed:
-Client #1 had calls to EMS in 2024 and 2025 with medical complaints and psychiatric issues.
-Client #1 was "the only one calling (EMS)."
-EMS was not aware the facility was a licensed group home.
-From 1/9/25 to 7/31/25, there were 8 EMS calls in which Client #1 had no staff present with him when EMS arrived at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 9 -"We make a lot of noise when we arrive with our sirens and lights so I'm surprised no staff can hear us coming to the home (facility)." Interview on 8/6/25 with Staff #2 revealed: -The last time Client #1 called EMS was the night of 7/30/25. -He was aware Client #1 had a history of calling EMS from the facility's phone when he (Staff #2) was in the staff bedroom or asleep. -"...he gets the phone off the base and calls EMS and then walks outside to meet up with them (EMS) and go to the hospital." -"One time [Client #1] called the ambulance while he was at the store." -"I was working on shift (night of 7/30/25). I was asleep. When I sleep, I close my door so they (Clients #1, #2, #3 and #4) won't mess with me." -"I don't know what hospital he (Client #1) went to. I don't know how long he was at the hospital because I left work the next day(morning of 7/31/25)." Interviews on 8/5/25 and 8/15/25 with the Administrator revealed: -8/5/25, She confirmed Client #1 was at the facility. -"(The) time before this past time (prior to his 2nd hospitalization on 7/31/25), he (Client #1) called his mother to pick him up (from the hospital) and she called the house (facility) and said he needed to be picked up on [named] road . I drove to [named] road looking for him and couldn't find him." -8/15/25, "This should not be happening," in response to to Staff #2 closing his door when he went into the staff bedroom. Review on 8/15/25 of a Plan of Protection completed and dated 8/15/25 by the Administrator	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 10 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -To prevent an incident as the example given and ensure the safety of the consumers in our care, NOA (Licensee) will: -Hold an emergency staff meeting to discuss the incident and reinforce the expectation that staff must remain alert and aware of all activity in and around the facility. -Direct staff to monitor all facility entry points and to acknowledge the presence of outside personnel including agencies (such as EMS or law enforcement) immediately upon arrival. -Reiterate to staff to maintain visual awareness of client movement within the facility and ensure immediate follow-up with the QP if a client is observed leaving with outside personnel or without proper authorization. -Follow a mock-monitor on phone usage. Describe your plans to make sure the above happens. -To ensure Plans are adhered to, Noa will: -Staff must respond to all doorbell/knock/entry immediately to know who enters or exits the facility. -When outside agencies arrive, staff must notify supervisors and document the reason for their visit. -Staff must confirm and take note of the condition of any client leaving with outside personnel. -Install or reinforce the use of door alert systems such as shopkeeper bells/alarms at main entrances to ensure staff are aware of all arrivals. -Require staff to complete a client presence check (head count/roll call) at set intervals and after any outside agency visit.	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 11 -Brief staff monthly on environmental awareness, supervision standards, and communication during emergency responses. -Supervisors will conduct unannounced spot checks weekly for the next 90 days to monitor staff attentiveness and compliance." Review on 8/15/25 and 8/18/25 of an amended Plan of Protection completed and dated 8/15/25 by the Administrator revealed: -The beginning date for the immediate actions was identified as of August 15, 2025. -The "mock-monitor phone calls" was removed. -The content in "Describe your plans to make sure they above happens" was moved under the immediate actions section of the protection plan with a start date of August 15, 2025. -The section "Describe your plans to make sure the above happens" had "the licensee director" changed to "Administrator "and "will monitor the QP and staff to ensure the above actions are carried out by discussions with the QP and staff on a weekly basis." This facility serves clients with diagnoses of Schizophrenia, Schizoaffective Disorder and Depression. Between 1/9/25 and 7/31/25, Client #1 called emergency medical services 8 times to be transported to a hospital. In 7 out of the 8 calls for emergency medical services, there were no staff interactions with the emergency medical responders to provide information about Client #1's health and treatment services or to receive information about which hospital Client #1 was being transported to. On 7/30/25, Staff #2 closed his bedroom door to prevent Clients #1, #2, #3 and #4 from interaction with him. When Staff #1 came into work the morning of 7/31/25, he discovered from Clients #2, #3 and #4 that Client #1 called emergency medical services and was	V 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 115	Continued From page 12 transported at 1:00 am on 7/31/25 to a hospital. Client #1's whereabouts were unknown to the facility which led to a Missing Person's report on Client #1. Client #1 was returned to the facility on 8/3/25 by his mother and without Client #1's legal guardian being made aware of his return until 8/5/25. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 115		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 13 emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 4 of 4 clients (Client #1, #2, #3 and #4) were assessed for their capability to have unsupervised time in the facility and community. The findings are: Review on 8/7/25 of Client #1's record revealed: -Admission date of 11/17/23. -Diagnoses of Schizoaffective Disorder and Bipolar Disorder. -No documentation in Client #1's treatment plan dated 11/20/24 with unsupervised time in the facility and community. -2/18/25 assessment for Client #1 revealed he	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 14	V 290		

was assessed by the Qualified Professional (QP) for 2 hours of unsupervised time in the community.
-There was handwritten documentation on the unsupervised time assessment which stated "pending LG (Legal Guardian) signature."

Interviews on 8/5/25 and 8/11/25 with Client #1 revealed:
-He walked to a nearby store about a half mile away to meet "different people" which included his mother and "sometimes to buy stuff."
-When he went to the store, he did not have a staff with him.
-"I go (to the store) by myself."

Interviews on 8/5/25 and 8/7/25 with Client #1's private agency guardian revealed:
-She was the guardianship representative for Client #1.
-She had not signed Client #1's 11/20/24 treatment plan as her signature would have been followed by her guardianship credentials.
-Client #1 was not to have unsupervised time in the community.
-"A lot of times I go there (to the facility) and he's not there... I catch him walking out on the streets."
-"I'm concerned he's not getting the supervision he needs."
-Client #1 was not supposed to have contact with his mother due to a history of illicit substance use.

Review on 8/13/25 of Client #2's record revealed:
-Admission date of 4/3/17.
-Diagnoses of Schizophrenia, Schizoaffective Disorder Type and Anti-Social Personality Disorder.
-No documentation in Client #2's treatment plan dated 6/16/25 for unsupervised time in the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 15	V 290		

and community.
-6/14/19 assessment revealed "QP has approved for 3 hour (unsupervised time) for [Client #2] based on phone discussion with LG (Legal Guardian)," and "The unsupervised time assessment must be reviewed and re-approved on an annual basis or as circumstances change."
-There was no annual re-assessment of Client #2's unsupervised time in the facility and community.

Interview on 8/11/25 with Client #2 revealed:
-"I walk up and down the street. I go to the [named] store ...I go there on my own. I don't need anybody going with me."

Interview on 8/12/25 with Client #2's private agency guardian revealed:
-She was the guardianship representative for Clients #1 and #2.
-She was aware Client #2 was walking to a nearby store.
-"He (Client #2) has told me before he gets his weed there (at the store) and smokes it because he has been told by someone (unnamed) from the group home not to bring that (weed) back to the house (facility)."
-She was under the assumption unsupervised client time was allowed for all clients who lived at the facility.

Review on 8/13/25 of Client #3's record revealed:
-Admission date of 3/31/15.
-Diagnoses of Schizophrenia, Depression and Tobacco Use.
-No documentation in Client #3's treatment plan dated 5/10/25 for unsupervised time in the facility and community.
-No annual re-assessment of Client #3's unsupervised time in the facility and community.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 16 -No re-assessment of his unsupervised time after his arrest on 9/13/24. Interview on 8/11/25 with Client #3 revealed: -He was arrested on 9/13/24 for exposing his "privates," which was the reason he wore an ankle monitor. -"I can get out and walk even though I'm on probation and got this thing around my ankle. I walk to [named] store and buy my cigarettes. Probation says I can be out (in community) from 6 AM to 6 PM." Interview on 8/12/25 with Client #3's public guardian revealed: -Client #3 received guardianship services through the Department of Social Services. -The incident with Client #3's indecent exposure occurred at the store near the facility during a period he was allowed unsupervised time in the community. -Client #3 was arrested on 9/13/24 and was a registered sex offender. -"He is not to go to that store or be in the community near a school or public place where children might be present without a staff present with him." Review on 8/13/25 of Client #4's record revealed: -Admission date of 5/8/25. -Diagnosis of Schizoaffective Disorder. -Client #4's treatment plan dated 6/16/25 included a goal that he would "manage his supervised/unsupervised time when approved..." -No assessment of Client #4's capability for unsupervised time in the facility and community. Interview on 8/11/24 with Client #4 revealed: -"I don't live here. People say this is a group home."	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 17 -"I get out and walk around ...not far. I went to [named] store yesterday and walked back." Interview on 8/12/25 with Client #4's legal guardian revealed: -She was Client #4's legal guardian and his sister. -"They're (staff) not supposed to allow him unsupervised time without a staff." -"[QP] told me he was completing an assessment for [Client #4] on unsupervised time and would have it done within a few weeks but I haven't heard anything back from him about it (the assessment)." -Since his admission, Client #4 had been calmer in his behaviors but he was "still very delusional." Review on 8/11/25 of the facility's sign out sheets for the period from 5/13/25 to 8/11/25 revealed: -Each sheet had 5 columns with the headings "Date," "Name," "Destination," "Time Out, "and "Time In." -Documentation of all entries were handwritten. -Client #1's name occurred 3 times. -Client #2's name occurred 16 times. -Client #4's name occurred 27 times -In the "Name" column, there were 16 entries which were not legible. -In the "Sign Out" column, there were 27 undated entries. -In the Destination column, there were 31 entries to an unnamed store, 13 entries for walking, and at least 10 entries had destinations which were not legible. -In the "Time Out" column, 37 entries had no documentation whether the time was morning (AM) or evening (PM) and at least 8 written entries were not legible. -In the "Sign In" column, 28 entries had no documentation whether the time was AM or PM and at least 13 had no documentation of time.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 18 Interview on 8/6/25 with Staff # 1 revealed: -He worked as a direct care staff at the facility for about 2 ½ years. -He worked "2 days on and 2 days off, sometimes like that." -No other staff worked with him on his shift. -"We (staff) know who of our clients have unsupervised time. [QP] tells us." -"[Client #1] is always on the move. When he's supposed to eat, I look in his room and he's gone. He's gone walking down the street or to the store. Sometimes he signs out." -Client #3 and Client #4 did not have unsupervised time in the community. Client #1 and Client #2 had unsupervised time in the community. Interviews on 8/7/25 and 8/11/25 with Staff #2 revealed: -8/7/25, he worked as a direct care staff at the facility for about 7 or 8 months. -He worked Tuesdays and Wednesdays of every week. -Client #1 and Client #2 had unsupervised time, Client #3's unsupervised time was taken away when he was arrested, and Client #4 did not have unsupervised time. -8/11/25, Clients #1, #2 and #3 went in the community unsupervised "every day and at least twice a day to the store." -He did not know the reasons they went to the store because "I'm here when they go out. I don't know what they do there." -"I don't know why his (Client #4)'s name was on the sign out sheet." -He learned which clients had unsupervised time from the QP. Interview on 8/12/25 with the QP revealed:	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 290	Continued From page 19 -"Everybody but [Client #4] had unsupervised time. [Client #4] does not have it (unsupervised time) because he just came on board." "We can't restrict any of them (clients) from going out the door. Staff can stand at the door and try talking to them about not leaving but if they want to go out, they will." Interviews on 8/15/25 and 8/18/25 with the Administrator revealed: -8/15/25, "It is my personal opinion [Clients #1, #3 and #4] should not have unsupervised time in the community but this (decision) would have to left up to their treatment team and guardian to decide." -"[Client #4] does not go into the community. Every time I've been there, he's been watching TV or playing table tennis. He has never left the facility." -"I don't know why his (Client #4) name is on the sign out sheet because he doesn't leave the facility." -"We can't restrain a client or tie them down if they want to walk away. We can stand at the door and try to talk to them about staying and explain they don't have community hours and cannot go in the community but this hasn't stopped them." -8/18/25, "Either [Client #4] is signing out (of the facility) because he sees everyone else signing out or someone else is signing out under his name." This deficiency is cross referenced into 10A NCAC 27G . 0203 Competencies of Qualified Professional (V109) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 366	Continued From page 20	V 366		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 366	Continued From page 21 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 366	Continued From page 22 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately notify the Local Management Entity/Managed Care Organization (LME/MCO) within the facility's catchment area of all Level II incidents. The findings are: Review on 8/6/25 of an internal incident report signed by Staff #2 and dated 7/31/25 revealed: -"Client (Client #1) woke up in the middle of the night (7/30/25), called (an) ambulance and walked up the street and left. Staff was asleep and he (Client #1) left without permission." -Client #1 was taken to a hospital. -No documentation about what hospital he was transported to or that Client #1 was transported	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 366	Continued From page 23 by ambulance twice on 7/31/25 to a hospital. -Staff #2 notified the Qualified Professional of the 7/30/25 incident on 7/31/25 at an unknown time. Review on 8/12/25 of an Emergency Medical Services' (EMS) dispatch report for the period from 1/9/25 to 7/31/25 revealed: -Client #1 had 8 calls (1/9/25, 3/10/25, 4/7/25, 4/22/25, 6/28/25, 7/6/25, and twice on 7/31/25) to EMS for response which led him to be transported by EMS to a hospital. Review on 8/7/25 of an internal incident report dated 7/31/25 for Client #1 revealed: -The report was completed by the Administrator. -There was no documentation the LME/MCO in the catchment area was immediately notified of the 7/31/25 incidents in which Client #1 was transported by EMS to the hospital. Interview on 8/5/25 with the Administrator revealed: -She was responsible for notifying the LME/MCO immediately of all level II incidents.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 367	Continued From page 24	V 367		

becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 367	Continued From page 25 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all level II incidents in the North Carolina Incident Response Improvement System	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 367	Continued From page 26 (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review of internal incident reports for Client #1 by the facility from 6/17/25 to present date revealed: -No level II IRIS report was submitted for 6/28/25, 7/6/25, 7/30/25 and twice on 7/31/25. Interviews on 8/5/25, 8/7/25 and 8/18/25 with the Administrator revealed: -8/5/25, Client #1 had a history of calling emergency medical services (EMS) to be taken to the hospital. -"He (Client #1) runs out the back door, gets in (the) EMS van and is taken to the hospital. He has walked away from the hospital before and comes back to the house (facility). The time before this past time, he called his mother to come pick him up and she called and said he needed to be picked up on [named road]. I drove to [named road] looking for him and couldn't find him." -She had submitted an IRIS incident report for 7/31/25 for Client #1 and received a confirmation number but no symbol the report was successfully entered into IRIS. -She was aware of the steps to be taken for a successful IRIS report submission. -She was responsible for completing and submitting all of the facility's incident reports into IRIS. -8/7/25, she left (named IRIS staff) a voicemail to call her because Client #1's report for 7/31/25 was not successfully submitted into IRIS. -8/18/25, she had not heard back from the IRIS staff to discuss why her level II report on Client #1 was not successfully submitted into the IRIS system.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 738	Continued From page 27	V 738		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on record review and interview, the facility was not kept free from insects. The findings are: Review on 8/8/25 of a Division of Health Service Regulation (DHSR) construction survey dated 8/7/25 revealed: -" ... it was observed throughout the facility there were signs that the facility has/had bed bugs in the facility," and " ... it was observed that the facility had dead bed bugs in multiple rooms, as well as organic matter left behind by bedbugs including but not limited to baseboards, walls, and ceilings." Review on 8/11/25 of invoices from a pest control company from 3/24/25 to 7/15/25 revealed: -A technician visited the facility each month except for April 2025 and used chemicals which targeted "Bed bugs, Fleas and German roaches." -6/4/25, a follow-up visit by the pest control company for "treatment of active bed bugs on interior surface." Interview on 8/7/25 with the Biennial Residential Team Lead revealed: -There was a bed bug infestation in the facility and facility staff were verbally informed during his visit on this date, 8/7/25.	V 738		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 738	Continued From page 28 -There was evidence of live bed bugs in the middle bedroom and closet area, excrement from bed bugs and bed bug remnants were observed. Interview on 8/11/25 with Client #1 revealed: -I don't see any kind of bugs inside (facility). "Some man came here 1 ½ to 2 weeks ago and sprayed the house for bugs. That's why I don't see any." -His bedroom was the "middle bedroom" as he pointed to a middle exterior window. -"Never been bit by a bug." Interview on 8/11/25 with Client #2 revealed: -He had not seen any bugs inside the facility and had not been bitten by any bugs. Interview on 8/11/25 with Client #3 revealed: -"I had them (bed bugs) biting me on (my) arm 8 months ago." -Not seen any bed bugs lately." Interview on 8/11/25 with Client #4 revealed: -"No bed bugs here. No bugs biting me." Interview on 8/11/25 with the pest control company who had been treating the facility revealed: -Company notes showed the 1st treatment for bed bugs occurred on 8/4/24 due to "a heavy infestation. -Preparation work was required by the facility staff prior to a pest control treatment and included removing of all bedding, curtains, and clothing and having these items washed at a laundromat, vacuuming furniture and floors and disposing of vacuumed contents into a bag outdoors, and standing up all mattresses on their side. The technician then inspected the facility for completion of preparations and if not completed,	V 738		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-381	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES, INC	4328 STOKESDALE 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 738	Continued From page 29 the treatment appointment was rescheduled. -5/20/25, preparation work by the facility was not completed and treatment for bed bugs was rescheduled for 6/4/25. -No invoice for April 2025 treatment of bed bugs. -Re-infestation of bed bugs could occur if preparation work and clean up was not completed by the facility, and if used furniture and appliances were brought into the facility for use. Interviews on 8/5/25 with the Administrator revealed: -The facility was being treated by a pest control company on a "regular basis;" she would provide documentation for each pest control visit. -She had no knowledge of active bed bugs in the facility. -"The pest control company advised us (her and the Qualified Professional) that within 3 days of treatment, there may be bed bug activity because the (pest control) treatment draws the bugs out." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 738		