

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/30/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NOA HUMAN SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4328 STOKESDALE AVENUE</b> <b>WINSTON SALEM, NC 27101</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A follow up survey was completed on October 30, 2025. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 5 current clients.</p>	V 000		
V 109	<p><b>27G .0203 Privileging/Training Professionals</b></p> <p><b>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</b></p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p>	V 109		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 109	<p>Continued From page 1</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:</p> <p>Cross Reference: 10A NCAC 27G .5602 (V290). Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 clients (Client #1, #2, and #3) were assessed for their capability to have unsupervised time in the facility and community.</p> <p>Review on 10/21/25 of the QP's personnel record revealed: -A hire date of 2/27/16. -A job description of QP: Duties included working with the clients, guardians and treatment teams in developing client treatment plans and completing client assessments for unsupervised time.</p> <p>Review on 10/20/25 of the clients' #1, #2 and #3 assessment documentation revealed: -" ...Unsupervised time must be addressed in the PCP (Person Centered Plan)/Service Plan and</p>	V 109		

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V 109	<p>Continued From page 2</p> <p>documented on the PCP/Service Plan ..."</p> <p>Interviews on 10/20/25, 10/22/25 and 10/28/25 with the QP revealed:</p> <p>-10/20/25:</p> <p>-Client #1, #2, and #3's treatment plans did not have assessement's for unsupervised time in the facility and community.</p> <p>-The only clients that currently had unsupervised time were clients #4 and #5.</p> <p>-"[Client #3] does not have unsupervised time in the facility or the community, as he is a registered sex offender."</p> <p>-"No one (facility staff) told me they (Clients #1, #2 and #3) were still leaving the house (for unsupervised time in the community)."</p> <p>-"I am aware [Client #1] has left out (of the facility)."</p> <p>on 10/22/25.</p> <p>-"I told [Client #3] he can't leave (the facility)."</p> <p>on 10/28/25.</p> <p>-Had not assessed Client #1, #2 and #3's unsupervised time.</p> <p>-Had not reviewed the in/out log for unsupervised time for Clients #1, #2 and #3.</p> <p>-"I am not at the facility 24/7 so I don't know where the clients go (when they leave the facility unsupervised) ...They (staff) will call me (when a client who has not been assessed for unsupervised time leaves the facility) and I call the legal guardian (local county's Department of Social Services). If we notify the police, then we do an incident report."</p> <p>-He had conducted an in-service with staff regarding monitoring and supervision during night hours, but there was no documentation of the in-service.</p> <p>-He was involved in the every day-to-day operation of the facility.</p>	V 109		

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V 109	<p>Continued From page 3</p> <p>Review of the facility's Plan of Protection, dated 10/30/25 and written by the Administrator/Licensee revealed:</p> <p>- "What immediate action will the facility take to ensure the safety of the consumers in your care? NOA (The Licensee) will immediately seek and schedule a qualified trainer for the qualified professional through either the DHHS (Department of Health and Human Services) NC (North Carolina) Program or any qualified trainer. This training will focus on the essential and fundamental clinical knowledge skills for creating and implementing client assessment and treatment plan/planning. Additional training will focus on crisis intervention, proper documentation, medication administration and seizure management.</p> <p>- Describe your plans to make sure the above happens. Implement a detailed intervention plan to include prevention of challenging behaviors with proactive measures to decrease the need for reactive responses, such as constant contact with [a local police department] &amp; IRIS (Incident Response Improvement System) reporting. Reinforcing positive behaviors through re-directing the consumers, safety assurance; reducing the number of consumer improper exits, effectiveness monitoring &amp; documentation, quality assurance, NOA will assess the above-mentioned plan, measure the effectiveness of protocols &amp; adjust the guidelines as needed. The Administrator will continue weekly supervision of the Qualified Professional."</p> <p>This facility serves 5 clients with mental health diagnoses which include Schizophrenia, Schizoaffective Disorder and Depression. Clients #1, #2, and #3 were leaving the facility unsupervised and going out into the community. Clients #1, #2, and #3 did not have assessments</p>	V 109		

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V 109	<p>Continued From page 4</p> <p>which determined each of their capabilities to have unsupervised time in the facility and community. Clients #1, #2 and #3 had been in the community unsupervised approximately 79 times since September 11, 2025. There was no assessments of 2 clients' (Clients #2 and #3) abilities on an annual basis or as their capabilities changed. Client #3 was observed smelling like alcohol and admitted to buying and drinking alcohol when going into the community unsupervised. Client #3 was a registered sex offender and had been arrested for exposing himself publicly to a minor, but he was allowed to go into the community unsupervised and had not been assessed for unsupervised time in the community. The Qualified Professional (QP) was not aware client #3 drank beer after leaving the facility unsupervised on 10/22/25. Assessments and reassessments for unsupervised time were the responsibility of the Qualified Professional but were not completed, updated and included in each clients' treatment plans.</p> <p>This deficiency constitutes a Continuing Type A 1 rule violation originally cited for serious neglect for failure to correct within 23 days.</p>	V 109		
V 115	<p>27G .0208 Client Services</p> <p>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.</p>	V 115		

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V 115	<p>Continued From page 5</p> <p>(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.</p> <p>(c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious.</p> <p>(d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide supervision to ensure the safety and welfare of 5 of 5 Clients (#1, #2, #3, #4 and #5). The findings are:</p> <p>Review on 10/21/25 of Client #1's record revealed: -Admission date of 11/17/23 -Diagnosis of Schizoaffective Disorder, Bipolar Type</p> <p>Review on 10/21/25 of Client #2's record revealed: -Admission date of 5/15/25 -Diagnosis of Schizophrenia</p> <p>Review on 10/21/25 of Client #3's record</p>	V 115		

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V 115	<p>Continued From page 6</p> <p>revealed: -Admission date of 3/31/25, Readmitted on 5/10/25 -Diagnoses of Schizophrenia, Depression and Tobacco Use</p> <p>Review on 10/21/25 of Client #4's record revealed: -Admission date of 5/8/25 -Diagnosis of Schizoaffective Disorder</p> <p>Review on 10/21/25 of Client #5's record revealed: -Admission date of 8/8/25 -Diagnoses of Schizophrenia Unspecified, Cannabis Use Disorder, Mild</p> <p>Interview on 10/30/25 with neighbor #1 revealed: -"I haven't seen any change in how much that guy (Client #3) is outside...you know, he will call out to my wife, my children or myself if we are outside...he will walk up and stand at the end of our driveway and call out to us...it has gotten worse..." -"He will walk up and down the street and knock on people's doors...I am just very concerned about that situation ...I have extremely low confidence in this facility and their staff to mitigate the risk posed to my family by that man's presence in our neighborhood..."</p> <p>Interview on 10/30/25 with neighbor #2 revealed: -The clients were in the neighborhood "everyday, day or night." -There was consistent begging for money and cigarettes, delivered packages have gone missing. -Another client stands in the middle of the street and asks for shoes. -"It doesn't surprise me that one of them is a sex</p>	V 115		

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V 115	<p>Continued From page 7</p> <p>offender. I have a little girl and when she goes outside, he peeks through the fence at her ...she has to be supervised while outside."</p> <p>Interview on 10/30/25 with neighbor #3 revealed: -There is one guy that comes over and asks for money and then the others come over and do the same. -"There is one client that stands in the road and talks to himself frequently." -"I've seen them go to both stores." -"EMS (Emergency Medical Services) and police have come out quite a bit."</p> <p>Interviews on 10/23/25 and 10/30/25 with staff #1 revealed: -"The facility is big, and clients could slip out (of the facility) and go into the community (without staff's knowledge)." -" I didn't have any extra training on monitoring and supervising the clients by the Qualified Professional (QP)...and I am not monitoring the clients any closer." -"I clock out at 10pm and I can't clock in until 8am." -Did not monitor any clients during sleep hours.</p> <p>Interview on 10/28/25 with staff #2 revealed: -Did not monitor any clients during sleep hours.</p> <p>Interviews on 10/21/25 and 10/28/25 with the QP revealed: -After 10pm, staff are allowed to sleep and must be up by 8am. -Had not created or revised a policy to monitor and supervise the clients during sleep hours. -There was no new trainings or in-services for the two staff regarding monitoring and supervision of the clients. -There was no policy or plan developed or</p>	V 115		

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V 115	<p>Continued From page 8</p> <p>implemented to address monitoring of the clients during times when staff are in their bedrooms or when staff were sleeping.</p> <p>-There was no increase in staffing during the evening or sleep hours.</p> <p>-There was no documentation of bed checks of clients during the night.</p> <p>Review on 10/30/25 of the facility's amended Plan of Protection, dated 10/30/25 and written by the Administrator/Licensee revealed:</p> <p>-"What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure the safety of the consumers in our care, NOA (the Licensee) will 1. Conduct regular meetings to discuss client safety, ensuring that staff monitors all facility entry points. This is to always ensure awareness by staff of all client whereabouts. 2. Maintaining a continuous visual awareness of client movement and all activities and immediately reporting any infractions to the qualified professional 3. Conduct a periodic bed check and properly document with time, dates and staff initial, any incidents should be immediately reported. 4. During the hours of sleep, the bed check will be conducted from 10pm periodically through 7am, to be done at 10pm when consumers retire, 12 midnight when the house shuts down, 4am and 7:30am.</p> <p>-Describe your plans to make sure the above happens. NOA will 1. Conduct periodic staff awareness training, 2 Require a daily staff update on daily activities to the qualified professional 3. Staff must respond to all daily entrance or exit activities and immediately report all incidents to the qualified professional 4. Install home security systems on all windows and exit doors with control panels in the staff room, and possibly the common area, this should notify staff on duty of all exits throughout the day and even at the hour</p>	V 115		

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V 115	<p>Continued From page 9</p> <p>of sleep."</p> <p>This facility serves clients with diagnoses of Schizophrenia, Schizoaffective Disorder and Depression. All of the clients would go on a daily basis to the homes of the neighbors of the facility to panhandle. Client #3 was on probation and was a registered sex offender and had been arrested and charged with exposing himself to a minor several months ago. Staff acknowledged and Client #3 also admitted to leaving the facility regularly unsupervised and engaged in the drinking of alcohol during that time. The facility did not address or increase the monitoring and supervision of clients during all shifts and did not develop and implement a system to monitor and supervise the clients during the sleep hours. The facility did not increase staffing during the sleeping hours and did not provide any extra training for staff in the monitoring and supervision of clients during the sleeping hours.</p> <p>This deficiency constitutes a Continuing Type B rule violation which is detrimental to the health, safety and welfare of the clients for failure to correct within 45 days.</p>	V 115		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(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.</p> <p>(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</p>	V 290		

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V 290	<p>Continued From page 10</p> <p>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.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(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 emergency back-up procedures determined by the governing body; or</p> <p>(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.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(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</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by:</p>	V 290		

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V 290	<p>Continued From page 11</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 clients (Client #1, #2, and #3) were assessed for their capability to have unsupervised time in the facility and community. The findings are:</p> <p>Review on 10/20/25 of Client #1's record revealed: -Admission date of 11/17/23. -Diagnosis of Schizoaffective Disorder, Bipolar Type. -Treatment plan dated 11/20/24 did not include an assessment for unsupervised time in the community or facility.</p> <p>Interview on 10/20/25 with Client #1 revealed: -He walked to "both stores (located near the facility one quarter of a mile away) to get out of here (facility)." -Staff did not go with him to the store. -Facility staff did not discuss with him about having unsupervised time in the facility and community. -"My unsupervised time is from 8:00 am to 10:00 pm."</p> <p>Review on 10/20/25 of Client #2's record revealed: -Admission date of 4/3/17. -Diagnoses of Schizophrenia, Schizoaffective Disorder Type and Anti-Social Personality Disorder. -Treatment plan dated 6/16/25 did not include an assessment for unsupervised time in the community or facility. -The last assessment for unsupervised time in the facility and community was dated 6/14/19 -There was no annual assessment of Client #2's unsupervised time in the facility and community.</p>	V 290		

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NAME OF PROVIDER OR SUPPLIER  <b>NOA HUMAN SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101</b>
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V 290	<p>Continued From page 12</p> <p>Interview on 10/20/25 with Client #2 revealed: -He walked to the store daily, "but I have to get permission (from facility staff) and I sign in and out." -Went to the store alone without staff.</p> <p>Observation at the facility on 10/22/25 for approximately three minutes at 3:49pm revealed: -Client #2 was observed walking up and down the road in front of the facility. -No facility staff were outside with Client #2.</p> <p>Interviews on 10/20/25 and 10/22/25 with Client #1 and Client #2's a private agency's Legal Guardian (LG) revealed: -Was the LG for both Clients #1 and #2. -Had discussed meeting with the Qualified Professional and treatment team, but nothing had been scheduled to discuss the assessments for unsupervised time for Clients #1 and #2. -"[Client #1] goes all the time (into the community). I was told [facility] did not have the staff to walk the streets with the clients." -"I really want [Client #1] and [Client #2] to move (out of the facility)..." -"Right now [Client #1] and [Client #2] do not have unsupervised time. I spoke with and emailed [QP] on 9/15 (2025) to revoke unsupervised time for [Client #1] and [Client #2]."</p> <p>Review on 10/20/25 of Client #3's record revealed: -Admission date of 3/31/15. -Diagnoses of Schizophrenia, Depression and Tobacco Use. -Treatment plan dated 5/10/25 did not include an approval or assessment for unsupervised time in the community or facility. -Was a registered sex offender, with a history of drinking alcohol and was arrested for indecent</p>	V 290		

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V 290	<p>Continued From page 13</p> <p>exposure of a minor.</p> <ul style="list-style-type: none"> <li>-No annual assessment of Client #3's unsupervised time in the facility and community.</li> <li>-No reassessment of his unsupervised time after his arrest on 9/13/24 for indecent exposure.</li> </ul> <p>Interview on 10/20/25 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>-Had been signing in and out every day at the facility for unsupervised time.</li> <li>-Went to the store up the street "which is a quarter of a mile up the road."</li> <li>-"I don't know how much unsupervised time they (facility staff) gave me."</li> <li>-"We have unsupervised time from 8 (am) to 10 (pm)."</li> <li>-Went to the store without any staff.</li> <li>-Also walked to the end of the street to exercise without staff present.</li> <li>-Was currently on probation (for indecent exposure) "but I got my ankle monitor taken off."</li> <li>-"My probation officer knows I go to the store."</li> </ul> <p>Observation at the facility and further interview, at approximately 3:30pm on 10/22/25 with Client #3 revealed:</p> <ul style="list-style-type: none"> <li>-The smell of alcohol was on client #3's breath.</li> <li>-"I am not supposed to drink alcohol or drugs."</li> <li>-Admitted to drinking a 16-ounce beer earlier in the day.</li> <li>-Bought the beer from the store and brought it back to the facility to drink it.</li> <li>-Walked to the store alone and without staff supervision.</li> <li>-Stated when he goes out into the community, "I takes my special assistance monies every Monday and buy beer to drink."</li> <li>-He admitted to getting 4 beers from a neighbor.</li> <li>-"I am 49 years old. If I want to drink beer I will."</li> </ul> <p>Observation on 10/29/25 from approximately</p>	V 290		

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V 290	<p>Continued From page 14</p> <p>12:39 pm to 12:43 pm of client #3 revealed: -Client #3 was leaving a local store a quarter of a mile from the facility on a busy highway without staff present.</p> <p>Interview on 10/20/25 with client #3's local county's Department of Social Services' LG revealed: -Client #3 was a register sex offender with a history of drinking alcohol. -Was aware client #3 was going to the store unsupervised. -The QP had not contacted her about client #3 assessment of unsupervised time in the community. -Received an email (date unknown) from the QP which stated client #3 would no longer have unsupervised time. -Was told by the QP that client #3 was at the facility intoxicated about a month ago (exact date unknown).</p> <p>Interview on 10/22/25 with client #3's Probation Officer revealed: -Was called by the QP once (date unknown) that Client #3 was drunk at the facility. -Acknowledge that client #3 was a registered sex offender. -Stated she was unable to give the terms and conditions of Client #3's probation as it was not public record. -Was made aware by facility staff client #3 was intoxicated during his unsupervised time -"I can't do anything unless I catch him (violating his probation)."</p> <p>Reviews on 10/21/25 and 10/29/25 of the facility's in / out log, from 9/11/25 to 10/27/25, revealed: -"Date", "Name", "Destination", "Time out" and "Time in" is listed on the form.</p>	V 290		

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V 290	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-All documentation was handwritten.</li> <li>-Client #1's name occurred 3 times.</li> <li>-Client #2's name occurred 17 times.</li> <li>-Client #3's name occurred 59 times.</li> <li>-There was one day when the date was not listed.</li> <li>-9 times the destination documented was illegible.</li> <li>-7 times the time clients left the facility was illegible.</li> <li>-7 times the time clients returned back to the facility was illegible.</li> <li>-6 times there were no am or pm times listed for the time the clients left the facility.</li> <li>-9 times there were no am or pm times listed for the time the clients returned to the facility.</li> </ul> <p>Interview on 10/20/25 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>-All the clients currently have unsupervised time.</li> <li>-"The clients only go to the store a quarter of a mile up the road for their unsupervised time."</li> <li>-No facility staff was with the clients when they went out into the community.</li> <li>-"We can't hold (restrain) the clients from leaving the facility. We can only tell them they aren't supposed to leave."</li> </ul> <p>Further interview on 10/23/25 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>-He did not think anyone had unsupervised time now.</li> <li>-Was not sure what changed so the clients could no longer have unsupervised time.</li> <li>-All the clients in the facility are going into the community unsupervised.</li> <li>-Called the QP to ask who had unsupervised time and stated "only [Client #4] has unsupervised time right now."</li> <li>-"The house (facility) is so big I don't know when they (the clients) are sneaking out."</li> </ul> <p>Interview on 10/22/25 with staff #2 revealed:</p>	V 290		

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V 290	<p>Continued From page 16</p> <p>-The clients go to the store and back on their unsupervised time." -No facility staff were with the clients when they used their unsupervised time in the community. -"I think [client #4] has one hour of unsupervised time. I am not sure about [client #2]. I would have to look. [Client #3] has 1 hour to two hours of unsupervised time. [Client #1] does not have unsupervised time." -The protocol for when the clients leave the facility to go into the community if they don't have unsupervised time is to "call [the QP], then call the police and then write an incident report." -"We can't stop them from leaving (the facility)."</p> <p>Further interview on 10/29/25 with staff #2 revealed: -Went to bed at the facility between 11:30pm and 12:00am -Conducted bedroom checks but did not document them.</p> <p>Interviews on 10/20/25, 10/22/25 and 10/28/25 with the QP revealed: -There were no assessments or that clients #1, #2, and #3 were approved to have unsupervised time in the community in their treatment plans after the last survey dated 8/18/25. -The only client that currently had unsupervised time was Client #4. -"[Client #3] does not have unsupervised time in the facility or the community." -"No one (facility staff) told me they (Clients #1, #2 and #3) were still leaving the house (for unsupervised time in the community)." 10/22/25: -Did not know the terms and condition of client #3's probation. -Was aware client #3 was intoxicated on 10/19/25 and informed the LG.</p>	V 290		

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V 290	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-Was aware client #3 was a registered sex offender and had a conviction of indecent exposure of a minor.</li> <li>-Was not aware client #3 drank alcohol on 10/22/25.</li> <li>-"No one told me about that. That falls back on the staff."</li> <li>-"I told [client #3] he can't leave (the facility)." 10/28/25:</li> <li>-Had not assessed client #1, #2 and #3's unsupervised time</li> <li>-Had not reviewed the in/out log for unsupervised time for Clients #1, #2 and #3.</li> <li>-He cannot restrict the clients from going out in the community.</li> <li>-"I am not at the facility 24/7 so I don't know where the clients go (when the clients leave the facility) ...they (staff) will call me (when a client leaves that does not have unsupervised time in the community) and I call the legal guardian. If we notify the police, then we do an incident report."</li> <li>-He was involved in the day-to-day operation of the facility.</li> </ul> <p>Interview on 10/28/25 with the Administrator/Licensee revealed:</p> <ul style="list-style-type: none"> <li>-The QP was responsible for assessing each client for unsupervised time after August 18th (2025).</li> <li>-Was not aware if there was any documentation for monthly QP notes on unsupervised time because "he keeps his files, and I keep mine."</li> <li>-Only 1 client (#4) had unsupervised time.</li> <li>-Was not sure if Clients #1, #2 and #3 had unsupervised time.</li> <li>"That was up to the QP when he assessed them after August 18th (2025)" but was not sure.</li> <li>-Had not reviewed the in/out log for unsupervised time for the clients.</li> <li>-"We cannot restrain them (clients) if they leave</li> </ul>	V 290		

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V 290	Continued From page 18  (the facility)..."  This deficiency is cross referenced into 10A NCAC 27G. 0203 Competencies of Qualified Professional (V109) for a Failure to Correct a Type A1 rule violation.	V 290		
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	V 366		

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V 366	<p>Continued From page 19</p> <p>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 by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p> <p>(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</p>	V 366		

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V 366	<p>Continued From page 20</p> <p>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 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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement a policy governing their response to Level II incidents as required and 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:</p>	V 366		

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V 366	<p>Continued From page 21</p> <p>Review on 10/30/25 of the facility's internal incident report from September 11, 2025 to October 30, 2025 and dated 10/19/25 revealed: -"[Client #3] left the house knowing he is not supposed to leave and got drunk and came back drunk. He was not permitted to leave the house, but he left anyways because he doesn't have unsupervised time. So, he is fond of doing that every time he gets paid on Mondays. He was told not to leave ..."</p> <p>Review on 10/30/25 of IRIS (Incident Response Improvement System) revealed: -No documentation of Client #3 leaving the facility unsupervised and returning to the facility intoxicated.</p> <p>Observation and further interview with Client #3, at approximately 3:30pm on 10/22/25 revealed: -Admitted to drinking a 16-ounce beer earlier in the day. -There was the smell of alcohol was on Client #3's breath. -Bought the beer from the store and brought it back to the facility to drink it.</p> <p>Interviews on 10/22/25 and 10/30/25 with the Qualified Professional revealed: -Was aware client #3 returned to the facility intoxicated after reviewing the internal incident report dated 10/19/25. -It was the responsibility of the Administrator/Licensee (A/L) to submit incident reports into IRIS. -"She (A/L) is responsible for imputing all the IRIS reports."</p> <p>Interview on 10/30/25 with the A/L revealed: -Did not have documentation regarding attending to the health and safety needs of Client #3</p>	V 366		

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V 366	Continued From page 22  involved in the incident, determining the cause of the incident, developing and implementing correct measures, developing and implanting measures to prevent similar incidents, assigning a person to be responsible for the implementation of the corrections and preventative measures.  This deficiency constitutes a recited deficiency and must be corrected within 30 days.	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 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.	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/30/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NOA HUMAN SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4328 STOKESDALE AVENUE WINSTON SALEM, NC 27101</b>
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V 367	<p>Continued From page 23</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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 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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/30/2025</b>
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V 367	<p>Continued From page 24</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report all level II incidents in the North Carolina Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 10/30/25 of the facility's internal incident report signed by staff #1 and dated 10/19/25 revealed: -"[Client #3] left the house knowing he is not supposed to leave, and got drunk and came back drunk. He was not permitted to leave the house, but he left anyways because he doesn't have unsupervised time. So, he is fond of doing that every time he gets paid on Mondays. He was told not to leave ..."</p> <p>Review on 10/30/25 of IRIS (Incident Response</p>	V 367		

Division of Health Service Regulation

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V 367	<p>Continued From page 25</p> <p>Improvement System) revealed: -No documentation of the incident of Client #3 leaving the facility and returning to the facility intoxicated.</p> <p>Observation and further interview with Client #3, at approximately 3:30pm on 10/22/25 revealed: -The smell of alcohol was on Client #3's breath. -Admitted to drinking a 16-ounce beer earlier in the day. -Bought the beer from the store and brought it back to the facility to drink it. -"Once every week, when I get paid, I go to the store and buy beer."</p> <p>Interview on 10/20/25 with client #3's a local county Department of Social Service's Legal Guardian revealed: -Was made aware of Client #3 being intoxicated by the Qualified Professional (QP).</p> <p>Interviews on 10/22/25 and 10/30/25 with the QP revealed: -Was aware Client #3 returned to the facility intoxicated after reviewing the 10/19/25 after reviewing the internal incident report dated 10/19/25. -It was the responsibility of the Administrator/Licensee (A/L) to submit incident reports into IRIS. -"She (A/L) is responsible for imputing all the IRIS reports."</p> <p>Interview on 10/30/25 with the A/L revealed: -Was responsible for submitting level II incident reports into IRIS. -Was aware of the incident dated 10/19/25 with Client #3 returning to the facility intoxicated and failed to submit a level II incident report.</p>	V 367		

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V 367	Continued From page 26  This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 367		