

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on 4/7/26. The complaints were substantiated (intake #'s NC00235916 and NC00236055). 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>The facility is licensed for 6 and currently has a census of 7. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and</p>	V 118		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 1</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure medications were administered to clients on the written order of a person authorized by law to prescribe drugs, to keep current MARs and to document MARs immediately after administration for 3 of 3 audited clients (1, #2 and #3). The findings are:</p> <p>Review on 3/24/26 of Client #1's record revealed: -Admission date of 1/15/26; -Diagnoses included schizoaffective disorder , depressive type; obsessive compulsive disorder (OCD); tardive dyskinesia (TD); nicotine dependence; hypertension; acid reflux; obesity; eczema; and allergic rhinitis; -MARs for the months of January 2026 - March 2026 included the following medications documented as administered to Client #1: -Amlodipine Besylate 10 milligrams (mg) (hypertension), take 1 tablet by mouth (po) daily at 8am; -Atorvastatin 10mg (hypertension), take 1 tablet po daily 8am; -Austedo 6 mg (TD), take 1 tablet po twice daily (BID) 8am and 8pm;</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Benzotropine Mesylate .5mg (TD), take 1 tablet po at bedtime 8pm; -Bupropion Hydrochloride (HCL) Sustained Release 200mg (depression), take 1 tablet po at bedtime 8pm; -Fluoxetine HCL 10mg (OCD), take 1 capsule po daily 8am; -Fluoxetine HCL 20mg, take 1 capsule po daily 8am; -Losartan Potassium 25mg (hypertension), take 1 tablet po daily 8am; -Vitamin B-1 100mg (deficiency), take 1 tablet po daily 8am; -Vitamin C 500mg (deficiency), take 1 tablet po daily 8am; <p>-No documentation of orders for:</p> <ul style="list-style-type: none"> -Amlodipine Besylate; -Atorvastatin; -Austedo; -Benzotropine Mesylate; -Bupropion Hydrochloride; -Fluoxetine; -Fluoxetine HCL; -Losartan Potassium; -Vitamin B-1; -Vitamin C 500mg. <p>Observation on 3/24/26 from approximately 9:50am - 9:55am of Client #1's medications revealed Benzotropine Mesylate was not available.</p> <p>Interview on 3/24/26 with Client #1 revealed:</p> <ul style="list-style-type: none"> -Morning medications were supposed to be administered at 8am; -He had been administered his morning medications later in the day than ordered but he wasn't sure how often; -There had been times that he wasn't administered his medications at all..."at least twice before." 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 3</p> <p>Review on 3/24/26 of Client #2's record revealed: -Admission date of 6/7/23; -Diagnoses included schizoaffective disorder; bipolar disorder; diabetes and hypertension; -MARs for the months of January 2026 - March 2026 included the following medications documented as administered to Client #2: -Jardiance 25mg (diabetes), take 1 tablet po daily 8am; -Lisinopril 30mg (hypertension), take 1 tablet po daily 8am; -Metformin HCL 1,000mg (diabetes), take 1 tablet po BID 8am and 8pm; -No documentation of orders for: -Jardiance; -Lisinopril; -Metformin HCL.</p> <p>Interview on 3/24/26 with Client #2 revealed: -Morning medications were supposed to be administered at 8am; -He had been administered his medications later in the day than ordered before but wasn't sure how often (unable to identify a time period); -There had been times that he wasn't administered his medications at all but wasn't sure how often (unable to identify a time period).</p> <p>Review on 3/24/26 of Client #3's record revealed: -Admission date of 5/11/2016; -Diagnoses included schizophrenia; hypertension; and hyperlipidemia; -MARs for the months of January 2026 - March 2026 from approximately 10:20am - 10:30am included the following medications documented as administered to Client #3: -Clozapine 100mg (schizophrenia), take 3 tablets po at bedtime 8pm; -Initials of Staff #1 for Clozapine on 3/24/26</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 4</p> <p>which indicated he had administered the medication;</p> <ul style="list-style-type: none"> -Fluticasone Propionate 50 micrograms (allergies), use 1 spray in each nostril once daily 8am; -No documentation that Fluticasone Propionate had been administered on 3/24/26; -Lithium Carbonate 300mg (mania), take 2 tablets po BID 8am and 8pm; -No documentation that Lithium Carbonate had been administered on 3/24/26; -Loratadine 10mg (antihistamine), take 1 tablet po daily 8am; -No documentation that Loratadine had been administered on 3/24/26; -Losartan Potassium 25mg (hypertension), take 1 tablet po daily 8am; -No documentation that Losartan Potassium had been administered on 3/24/26; -Metoprolol Tartrate 50mg (hypertension), take 1 tablet po BID with food 8am and 5pm; -No documentation that Metoprolol Tartrate had been administered on 3/24/26; -Omeprazole Delayed Release 40mg (acid reflux), take 1 capsule po in the morning 8am; -No documentation that Omeprazole had been administered on 3/24/26; -Vitamin D2 1.25mg (deficiency), take 1 capsule po every week; -Initials that indicated Vitamin D2 had been administered 3/2/26, 3/3/26, 3/9/26 and 3/24/26; -Lorazepam 1mg (anxiety), take 1/2 in the morning and 1/2 in the evening 8am and 8pm; -No documentation that Lorazepam had been administered on 3/24/26; -No documentation of orders for: <ul style="list-style-type: none"> -Clozapine; -Lithium Carbonate; -Metoprolol Tartrate; -Omeprazole Delayed Release; 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 5</p> <p>-Vitamin D2; -Lorazepam.</p> <p>Observation on 3/24/26 from approximately 10:30am - 10:35am of Client #3's medications revealed Lorazepam was not available.</p> <p>Interview on 3/24/26 with Client #3 revealed: -He routinely was administered medications later than ordered..."at least once a month;" -There had been times that he wasn't administered his medications at all..."at least once a month."</p> <p>Review on 3/27/26 of Staff #1's record revealed: -A hire date of 6/20/22; -A job description of a Direct Care Staff; -Documentation that medication administration training had been completed on 3/21/26.</p> <p>Interview on 3/27/26 with a representative from the pharmacy utilized by the facility revealed: -Benzotropine had not been refilled for Client #1 by facility staff since January 2026; -If Benzotropine was administered as ordered to Client #1, he should have been out of medication at the end of February 2026; -There was no order history of Lorazepam for Client #3.</p> <p>Interview on 3/24/26 with Staff #1 revealed: -He had worked for the company for 3 years and he had worked at the current facility for 5 months; -Completed Medication Administration training annually; -Verified that morning with the Qualified Professional (QP) that Benzotropine had been refilled for Client #1 and Lorazepam had been refilled for Client #3 and both medications were scheduled to be delivered by the end of the day;</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Administered Benzotropine and Lorazepam to Client #1 the evening before (3/23/26); -Administered Client #3's medications as ordered but had failed to document the MAR; -It was the responsibility of the QP to obtain the medication orders, and it was his responsibility to maintain the orders in the clients' files; -Informed by the facility Owner to ensure that the MARs were completely filled out; -He filled in any blanks with his initials which indicated that he administered the medication. <p>Interview on 3/24/26 with the QP revealed:</p> <ul style="list-style-type: none"> -Staff #1 must have misunderstood him about refilling medications; -He had not requested refills for medications for Clients #1 or #3 but was going to ensure the pharmacy was contacted to see why the medications were not at the facility. <p>Interviews on 4/6/26 and 4/7/26 with the facility Owner revealed:</p> <ul style="list-style-type: none"> -MARs were required to be documented as medication was administered to clients; -She was not aware that medication orders were required to be in the clients' files; -Some medical providers refused to provide a copy of the medication orders to the facility; -She was not aware that any clients had missed their medications; -After she had discussed with the pharmacy on 4/6/26 why Client #1 missed taking Benzotropine in March, she determined it was the fault of the medical provider for not calling in an order for the medication; -She had reviewed MARs at the facility every other week but that wasn't enough; -She had informed staff to ensure that MARs were documented and there were no blanks but she didn't mean for staff to document if they 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	<p>Continued From page 7</p> <p>hadn't administered the medication.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by their physician.</p> <p>Review on 4/7/26 of the Plan of Protection signed and dated 4/7/26 by the facility Owner revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? NOA (NOA Human Services III, Inc) will engage in a weekly med (medication) audit, engage frequently with the pharmacy to ensure reviews on up to date meds.</p> <p>Describe your plans to make sure the above happens. We will engage in a weekly med audit, ensuring every order is properly filed, ensuring right medication for the right consumer."</p> <p>This deficiency was cited 4 times on 12/7/23, 3/6/25, 5/28/25, and 9/17/25.</p> <p>This facility served adults with Mental Illness with diagnoses which included schizophrenia; bipolar disorder; schizoaffective disorder, depressive type; obsessive compulsive disorder; tardive dyskinesia; nicotine dependence; hypertension; acid reflux; obesity; hyperlipidemia; eczema and allergic rhinitis. Client #1, diagnosed with tardive dyskinesia, had not been administered Bzotropine as ordered since February 2026. One medication for Client #3 was initialed which indicated it was administered approximately 9 hours early and 7 medications were not documented as having been administered and were approximately 2 hours late. Nineteen medications were being administered to Clients</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 118	Continued From page 8 #1, #2 and #3 with no physician orders. This deficiency constitutes a Type B rule violation for serious harm and must be corrected within 45 days.	V 118		
V 138	27G .0404 (A-E) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (a) An initial license shall be valid for a period not to exceed 15 months from the date on which the license is issued. Each license shall be renewed annually thereafter and shall expire at the end of the calendar year. (b) For all facilities providing periodic and day/night services, the license shall be posted in a prominent location accessible to public view within the licensed premises. (c) For 24-hour facilities, the license shall be available for review upon request. (d) For residential facilities, the DHSR complaint hotline number shall be posted in a public place in each facility. (e) A facility shall accept no more clients than the number for which it is licensed. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to serve no more clients than the number for which it was licensed, affecting 7 of 7 clients (#1, #2, #3, #4, #5, #6 and #7). The findings are:	V 138		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 138	<p>Continued From page 9</p> <p>Review on 2/20/26 of the facility's license issued by the Division of Health Service Regulation (DHSR) valid through 12/31/26 revealed a residential capacity of 6 clients.</p> <p>Review on 3/6/26 of the survey results from the DHSR Construction Section complaint survey completed on 3/3/26 revealed: -"At the time of the survey, it was observed that the facility was over capacity; -The facility is licensed for 6 beds; -The facility is currently serving 7 clients; -This is not compliant with the rule."</p> <p>Interview on 2/25/26 with Former Staff #4 revealed: -When he resigned on 2/7/26, there were 7 clients that resided in the facility; -Client #1 was the last client to move into the facility and that was in January 2026.</p> <p>Interview on 3/24/26 with Staff #1 revealed: -He was aware that the facility was licensed to serve 6 clients; -The facility served 7 clients from January 2026 until March 2026.</p> <p>Interviews on 3/3/26 and 4/6/26 with the facility Owner revealed: -The facility was licensed for 6 clients; -As of 3/3/26, there were 7 clients residing at the facility; -A sister facility was closed and there was nowhere for Client #1 to be moved to; -"It's kind of difficult for us to find placement (for Client #1). He's a sex offender. There's schools around.;" -She attempted to move other clients out of the facility to a sister facility but, "nobody wants to move;"</p>	V 138		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 138	Continued From page 10 -She also attempted to find alternative placement for Client #1; -"I Googled group homes and I called;" -She had not contacted the Local Management Entity/Managed Care Organization for assistance; -As of 4/6/26, there were 5 clients residing at the facility; -That's (served more clients than licensed capacity) corrected now."	V 138		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 291	<p>Continued From page 11</p> <p>inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have activity opportunities based on client's choices, needs and the treatment plan and designed to foster community inclusion affecting 2 of 3 audited clients (#1 and #2). The findings are:</p> <p>Review on 3/24/26 of Client #1's record revealed: -Admission date of 1/15/26 from a sister facility; -Diagnoses included schizoaffective disorder, depressive type, obsessive compulsive disorder, tardive dyskinesia, nicotine dependence, hypertension, acid reflux, obesity, eczema and allergic rhinitis; -Client #1 was declared incompetent and an agency was appointed as his legal guardian; -Treatment Plan updated 5/10/25 and 11/25/25 included, "At my PSR (Psychosocial Rehabilitation) program people like me because am very helpful and minds my own business...10 minutes a day has been approved for [Client #1] by his LG (legal guardian), for unsupervised time. This minutes will be used with 8am and sundown...Will continue to encourage [Client #1] to implement calming strategies - counting to 20, taking deep breath...Encourage [Client #1] to consider other options to vent his anger than hitting on himself-taking a walk around the block, listening to radio or watching his favorite program on TV (television);" -Medication Management Initial Assessment dated 7/11/25 included..."likes to go to a day</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 291	<p>Continued From page 12</p> <p>activity program, play basketball, play video games, watch TV, listen to music, and walk for fun."</p> <p>Interview on 3/24/26 with Client #1 revealed: -Facility activities included watching television and drinking coffee; -He wanted games, basketball and music included as activities; -He wanted to return to the day program but was informed by the Qualified Professional (QP) that he wasn't allowed to go back because of his criminal charges.</p> <p>Interview on 3/23/26 with Client #1's Guardian revealed: -Client #1 had complained to her about the lack of activities at the facility; -She was informed by the QP that Client #1 wasn't allowed to return to the day program because of his legal situation; -According to the QP, he hadn't been able to locate another day program that was willing to accept the client; -"He gets bored and tends to get in trouble. He will go out and get drunk;" -"I know he enjoys riding around...I don't want him to just sit in the house."</p> <p>Review on 3/24/26 of Client #2's record revealed: -Admission date of 6/7/23; -Diagnoses included schizoaffective disorder and bipolar disorder; -Client #2 was declared incompetent and an agency was appointed as his legal guardian; -Treatment Plan updated 9/16/25 included, "2 hours of unsupervised time has been approved, this will be used within the hours of 8am and 7pm...Continue to encourage [Client #2] to participate in activities that will continue to</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 291	<p>Continued From page 13</p> <p>enhance his recovery."</p> <p>Interview on 3/24/26 with Client #2 revealed: -There were no facility activities other than the television and unsupervised time available; -He wanted to be able to listen to music.</p> <p>Interview on 3/9/26 with Client #2's Guardian revealed: -"I hate NOA doesn't really do that (activities);" -She didn't understand why facility staff weren't able to take the clients to a store or out to eat occasionally.</p> <p>Interview on 3/24/26 with Staff #1 revealed: -He was not aware of any activities that he was supposed to encourage Clients #1 and #2 to participate in; -Clients either stayed in their bedrooms, watched tv, talked, or went outside; -He was not aware of a radio or games in the facility that the clients had access to.</p> <p>Interview on 4/7/26 with Staff #2 revealed: -He was not aware of any activities that he was supposed to encourage Clients #1 and #2 to participate in; -The clients, "they watch tv and go outside and smoke;" -Clients walked to a local fast food restaurant if they wanted to go somewhere.</p> <p>Interview on 4/7/26 with Staff #3 revealed: -She had informed the QP and the Owner for approximately a year that the clients needed more activities to do; -During COVID, the clients were used to not going anywhere or doing anything; -"They're (clients) still like on COVID lockdown;" -"They (clients) need to do something;"</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 291	Continued From page 14 -"I really think it would be so much better for them (clients) to be active in something." Interview on 4/6/26 with the facility Owner revealed: -There were activities available at the facility for the clients to do; -"There's radio. There's tv. Card game;" -"When it's time to initiate (activities), they want to watch tv instead."	V 291		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 15</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility staff failed to ensure the least restrictive and most appropriate settings and methods were used for 3 of 3 audited clients (#1, #2 and #3). The findings are:</p> <p>Observation on 3/24/26 from approximately 9:15am - 9:45am of the facility revealed: -All non-refrigerated food in the facility was stored in a kitchen pantry which was locked; -Staff #1 utilized a key to unlock the pantry door; -The gate for the fenced in backyard contained 2 locks that required keys.</p> <p>Review on 3/24/26 of Client #1's record revealed: -Admission date of 1/15/26; -Diagnoses included schizoaffective disorder, depressive type, obsessive compulsive disorder, tardive dyskinesia, nicotine dependence, hypertension, acid reflux, obesity, eczema and allergic rhinitis; -Client #1 was declared incompetent and an agency was appointed as his legal guardian; -No documentation regarding the need for the locked food cabinet or the locks on the gate in the backyard.</p> <p>Review on 3/24/26 of Client #2's record revealed: -Admission date of 3/24/26; -Diagnoses included schizoaffective disorder and bipolar disorder; -Client #2 was declared incompetent and an agency was appointed as his legal guardian; -No documentation regarding the need for the locked food cabinet or the locks on the gate in the backyard.</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	--

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 16</p> <p>Review on 3/24/26 of Client #3's record revealed: -Admission date of 5/11/16; -Diagnoses included schizophrenia, hypertension and hyperlipidemia; -Client #3 was declared incompetent and an agency was appointed as his legal guardian; -No documentation regarding the need for the locked food cabinet or the locks on the gate in the backyard.</p> <p>Review on 3/6/26 of the survey results from the Division of Health Services Regulation (DHSR) Construction Section biennial follow up survey completed on 4/30/25 revealed: -"At the time of the survey, it was observed the rear fence had multiple locking mechanisms on the gate; -This is not compliant with the rule; -Take the necessary steps to remove all the mechanisms on the gate that will require special tools/keys to exit the gate if locked."</p> <p>Review on 3/6/26 of the survey results from the DHSR Construction Section complaint survey completed on 3/3/26 revealed: -"At the time of the survey, it was observed the rear fence had multiple locking mechanisms on the gate; -This is not compliant with the rule; -Take the necessary steps to remove all the mechanisms on the gate that will require special tools/keys to exit the gate if locked; -This deficiency was previously cited during our 2025 biennial follow-up survey and action hasn't been taken to address the deficiency."</p> <p>Interview on 3/24/26 with Staff #1 revealed: -All non-refrigerated food in the facility was kept locked in the kitchen pantry so the clients didn't</p>	V 513		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 513	<p>Continued From page 17</p> <p>take it all; -He was informed to keep the pantry locked by the facility Owner; -He was not aware why there were locks on the gate in the backyard and didn't think he had keys for the locks.</p> <p>Interview on 4/7/26 with Staff #3 revealed: -All non-refrigerated food in the facility was kept locked in the kitchen pantry so the clients didn't take it; -She was informed to keep the pantry locked by the QP and the Owner.</p> <p>Interviews on 4/6/26 and 4/7/26 with the facility Owner revealed: -"We have a pantry that is unlocked and we have one that is locked; -The refrigerator is unlocked; -If we leave everything unlocked, you will find someone coming out after midnight and cooking; -The kitchen has been opened until midnight; -For the safety of themselves and every other client there (facility), we lock up all the food that needs to be cooked;" -The facility was purchased with the locks on the gate, and they had no keys to the locks; -She wasn't aware the locks on the gate in the backyard were requested to be removed..."That's my first time hearing it;" -"I will have it (locks) removed."</p>	V 513		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 736	<p>Continued From page 18</p> <p>odor.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility was not maintained in a safe, clean and attractive manner. The findings are:</p> <p>Observation on 3/24/26 of the facility from approximately 9:15am - 9:45am revealed: -Plastic flowerpot utilized as an ashtray, approximately 1/4 full of cigarette butts and ashes located in the outdoor smoking area; -Wooden kitchen stool cushion ripped approximately 5" wide all the way across the stool; -Outer edges of the basement bathroom door covered in tape; -The exhaust fan in the basement bathroom was making a grinding noise and not operating correctly; -Facility staff #1 pointed out staff sleeping quarters; -Facility staff sleeping quarters were located in a room in the basement with no windows or secondary egress.</p> <p>Review on 3/6/26 of the Statement of Deficiency (SOD) from the Division of Health Service Regulation (DHSR) Construction Section biennial follow-up survey dated 12/4/24 revealed: -"At the time of the survey it was observed that the full bath in the basement exhaust fan was seized and not operating as intended; -This is not compliant with the rule; -Take the necessary steps to correct these deficiencies."</p> <p>Review on 3/6/26 of the SOD from the DHSR Construction Section biennial follow-up survey</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 736	<p>Continued From page 19</p> <p>dated 4/30/25 revealed:</p> <ul style="list-style-type: none"> -At the time of the survey, it was observed that the facility was using a plastic receptacle for cigarettes; -This is not compliant with the rule; -Take the necessary steps to replace it with a metal receptacle; -At the time of the survey it was observed that the full bath in the basement exhaust fan was seized and not operating as intended; -This is not compliant with the rule; -Take the necessary steps to correct this deficiency; -This deficiency was previously cited during our December 04, 2024, biennial survey, take action to correct this deficiency; -At the time of the survey, it was observed that the facility had a bedroom downstairs that was utilized by staff that did not have an emergency egress window; -This is not compliant with the rule; -Take the necessary steps to remove the bed from the room as this is not considered a habitual sleeping area; -If the facility would like to have sleeping staff take the necessary steps to submit a project to decrease capacity so staff has a habitable bedroom for sleeping." <p>Review on 3/6/26 of the SOD from the DHSR Construction Section complaint survey dated 3/3/26 revealed:</p> <ul style="list-style-type: none"> -At the time of the survey, it was observed that the facility was using a plastic receptacle for cigarettes; -This is not compliant with the rule; -Take the necessary steps to replace it with a metal receptacle; -This deficiency was previously cited during our 2025 biennial follow-up survey and action hasn't 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 736	<p>Continued From page 20</p> <p>been taken to address the deficiency;</p> <p>-At the time of the survey it was observed that the full bath in the basement exhaust fan was seized and not operating as intended;</p> <p>-This is not compliant with the rule;</p> <p>-Take the necessary steps to correct this deficiency;</p> <p>-Bathroom was locked, and per Qualified Professional area was under repair;</p> <p>-This deficiency was previously cited during our December 04, 2024, biennial survey, take action to correct this deficiency;</p> <p>-This deficiency was previously cited during our 2025 biennial follow-up survey and action hasn't been taken to address the deficiency;</p> <p>-At the time of the survey, it was observed that the facility had a bedroom downstairs that was utilized by staff that did not have an emergency egress window;</p> <p>-This is not compliant with the rule;</p> <p>-Take the necessary steps to remove the bed from the room as this is not considered a habitual sleeping area;</p> <p>-If the facility would like to have sleeping staff take the necessary steps to submit a project to decrease capacity so staff has a habitable bedroom for sleeping;</p> <p>-This deficiency was previously cited during out 2025 biennial follow-up survey and action hasn't been taken to address the deficiency."</p> <p>Interview on 3/3/26 with a DHSR Construction Section Surveyor revealed:</p> <p>-The amount of times that the facility had been cited for the same things was concerning;</p> <p>-Management wasn't taking into consideration the safety of the clients or the staff by allowing egress and fire hazards to continue;</p> <p>-"They're (clients and staff) not safe from a construction standpoint."</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 736	<p>Continued From page 21</p> <p>Interview on 3/24/26 with Staff #1 revealed: -He wasn't aware that using plastic as an ashtray was a safety issue because he didn't smoke; -Wasn't aware of how long the kitchen stool cushion had been ripped; -Facility Maintenance had been at the facility prior in the day and had taped the bathroom basement door because he was going to paint in the basement and didn't want to get paint on the door; -Wasn't aware that the exhaust fan in the downstairs bathroom wasn't working properly; -He wasn't aware that there had to be secondary egress in all bedrooms.</p> <p>Interview on 4/6/26 with the facility Owner revealed: -Everything in the basement bathroom, including the exhaust fan, was supposed to be repaired..."That I spent 4 grand on;" -She was not aware there was an egress issue with the facility bedroom in the basement..."Nope. I could move the staff to another room in the basement that has egress. It's a smaller room;" -She wasn't sure if the DHSR Construction Section had approved the room in the basement as a bedroom.</p> <p>Review on 4/7/26 of the Plan of Protection signed and dated 4/7/26 by the facility Owner revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The basement bathroom exhaust fan is functional The Padlocks on the outside gate will be removed Immediately The staff room will be moved to another section of the facility.</p> <p>Describe your plans to make sure the above happens.</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 736	<p>Continued From page 22</p> <p>N/A (Not applicable) - The exhaust fan is functional NOA (NOA Human Services III, Inc.) will contract a locksmith to have said locks removed within the week NOA will within 30 days fix and move the staff qtrs (quarters) to another section."</p> <p>This deficiency has been cited 3 times since the original cite on 3/6/25.</p> <p>The facility served 6 adults with diagnoses that included schizophrenia; bipolar disorder; schizoaffective disorder, depressive type; obsessive compulsive disorder; tardive dyskinesia; nicotine dependence; hypertension; acid reflux; obesity; hyperlipidemia; eczema and allergic rhinitis. During recent walk throughs of the facility and its grounds by two DHSR Sections, ongoing safety issues were observed with no evidence that efforts were made to address or resolve them. The facility was directed to correct the issues in 2024, 2025 and 2026. The facility failed to provide a safe environment, make repairs, and remove fire hazards. Emergency egress in the event of a fire was hindered by no window opening or other secondary egress in the staff bedroom. Clients and staff utilized a plastic flowerpot in the outdoor smoking area as an ashtray. Furniture needed to be replaced or repaired along with bathroom repairs. These are unsafe conditions for the clients and staff that reside and work in the facility. These deficiencies constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days.</p>	V 736		
V 738	<p>27G .0303(d) Pest Control</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p>	V 738		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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	<p>Continued From page 23</p> <p>(d) Buildings shall be kept free from insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility was not kept free from insects. The findings are:</p> <p>Review on 3/6/26 of the survey results from the Division of Health Service Regulation (DHSR) Construction Section complaint survey completed on 3/3/26 revealed: -"At the time of the survey, it was observed that the facility had bed bugs in multiple rooms, specifically in Bedroom #1 and Bedroom #2; -Numerous bed bugs were found on the walls and beds in both rooms; -This is not compliant with the rule; -Take the necessary steps to provide documentation from a qualified professional detailing the treatment plan in place; -Additionally, submit a plan from the facility on how it will monitor and clean up any organic residue left by the bed bugs."</p> <p>Interview on 3/3/26 with a DHSR Construction Section Surveyor revealed: -The "bedbugs were active in the day;" -"Activity during the day typically signals a large, established infestation."</p> <p>Interview on 3/24/26 with Client #1 revealed: -Since he had moved to the facility, he had observed bedbugs in his bedroom; -He had been bitten by bedbugs which left a red spot;</p>	V 738		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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	<p>Continued From page 24</p> <p>-Had informed his family that he had bedbugs in his bedroom and had been bitten; -Informed Staff #1 (unable to provide timeframe) that he had bedbugs in his bedroom and had been bitten.</p> <p>Interview on 4/1/26 with a family member of Client #1's revealed: -Since Client #1 had moved to the facility on 1/15/26, he had observed bedbugs in his bedroom; -Client #1 had complained of being bitten by bedbugs; -He had discussed his concerns with the Qualified Professional.</p> <p>Interview on 2/25/26 with Former Staff #4 revealed: -He had observed bedbugs in the facility from approximately August 2025 - February 2026; -He had thrown client #5's bed away in January 2026 and "that helped with the infestation but didn't cure it;" -He had informed the Qualified Professional that there was a bedbug problem; -There had not been anyone from pest control at the facility that he was aware of since August 2025.</p> <p>Interview on 3/24/26 with Staff #1 revealed: -He was aware that the facility had bedbugs; -Had been informed by the facility Owner that the bedbugs probably moved from the sister facility with Client #1.</p> <p>Interviews on 2/20/26 and 3/3/26 with the facility Owner revealed: -The facility had no bedbugs; -"The last time we had bedbugs was 2019;" -The last time pest control inspected the facility</p>	V 738		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 25 was in 2020; -She was advised by Staff #1 on 3/3/26 that the facility had bedbugs..."That's what I've just been advised. I'm going to reach out to [a local pest control company]."	V 738		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to have minimum furnishings for a client bedroom which included bedding. The findings are: Observations on 3/24/26 from approximately 9:15am - 9:45am of the facility revealed: -Client #1 had no sheets on his bed; -Client #1 had 2 blankets only on his bed. Interview on 3/24/26 with Client #1 revealed: -I don't have any sheets;	V 774		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NOA HUMAN SERVICES III, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106
--	---

(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 774	<p>Continued From page 26</p> <p>"I told [Staff #1]. He said he's going to call [the Qualified Professional (QP)]."</p> <p>Interview on 3/24/26 with Staff #1 revealed:</p> <ul style="list-style-type: none"> -Client #1 hadn't had any sheets on his mattress since he was admitted to the facility on 1/15/26 from a sister facility; -The sister facility had bedbugs, so the sheets were thrown away; -He had informed the QP within the last couple of days (exact date unknown) that Client #1 had asked for sheets; -The QP had been out of the country from January 2026 until the first of March and there had been no one that filled in for him. <p>Interview on 4/6/26 with the facility Owner revealed:</p> <ul style="list-style-type: none"> -She was not aware that Client #1 hadn't had any sheets on his bed since he was admitted to the facility on 1/15/26; -"I'll take care of that (sheets)." 	V 774		