NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 30, 2018

Ms. Juliet Okwoshah
Alpha Home Care Services Inc.
PO Box 41153
Raleigh, NC 27629

Re: Annual and Follow up Survey completed May 21, 2018
Alpha Home Care Services Inc., 202 Lindell Drive, Apex, NC 27502
MHL #092-920
E-mail Address: juliet@alphahealthservices.com

Dear Ms. Okwoshah:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed May 21, 2018.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 7/20/18.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski-Ames at 919-552-6847.

Sincerely,

Lesa Williams

Lesa Williams, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
File

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-920	A. BUILDING: _____ B. WING _____	R 05/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	202 LINDELL DRIVE APEX, NC 27539

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on May 21, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600A Supervised Living for Adults with Mental Illness.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure disaster drills were completed at least quarterly and repeated on each shift. The findings are: Review on 5/18/18 of the facility's disaster drills May 2017 - May 2018 revealed: - Disaster drills were documented as completed on a monthly basis Interview on 5/15/18 with client #2 revealed:	V 114		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL092-920 (Y1)	A. Building B. Wing (Y2)	5/21/2018 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	202 LINDELL DRIVE APEX, NC 27539

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0120 Reg. # 27G .0209 (E) LSC	Correction Completed 05/21/2018	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Lesa Williams	5/30/18
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/24/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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V 114	Continued From page 1 - She's been living at the facility since October 2010 - She had not participated in any disaster drills - In the event of a tornado, she would go into the laundry room, close the door and tuck her head down Interview on 5/15/18 with client #3 revealed: - She hasn't participated in any disaster drills - She would go downstairs in the event of a tornado - "I don't think this home has a downstairs" Interview on 5/15/18 with client #4 revealed: - She's lived in the facility since September 2016 - Disaster drills had not been discussed with them nor had they participated in any disaster drills Interview on 5/15/18 with client #5 revealed: - She's lived in the facility since November 2017 - She hasn't participated in any disaster drills since living in the facility Interview on 5/15/18 with staff #1 revealed: - She's live-in staff - Disaster drills were competed monthly Interview on 5/15/18 with the Qualified Professional (QP) revealed: - Staff were to complete disaster drills once a month Interview on 5/18/18 with the Licensee revealed: - Disaster drills were completed once a quarter - She also talked to the clients about disaster drills - To her knowledge, disaster drills were being	V 114	QP did conduct fire and disaster drills with staff and residents. However, staff will continue to do the fire and disaster drills on a quarterly basis. QP will supervise and ensure that the procedure is followed and residents participate in the process DHSR - Mental Health JUN 07 2018 Lic. & Cert. Section	6/6/18

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V 114	Continued From page 2 completed accordingly	V 114		
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 inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility	V 291		

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V 291	Continued From page 3 failed to ensure coordination was maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management for 1 of 3 audited clients (#6). The findings are: Review on 5/15/18 of client #6's record revealed: - Admission date: 7/14/14 - Diagnoses of Psychotic Disorder Not Otherwise Specified and Schizophrenia - March 2018 - May 2018 MAR (medication administration record): When Dizzy, please check and record call if BP (blood pressure) is less than 100/60 or greater than 180/100: Blood Pressure readings 4/4/18 - 98/59; 4/11/18 - 78/55; 5/7/18 - 79/60 and 5/14/18 - 75/63 - No documentation client #6's physician was contacted regarding the above readings Interview on 5/15/18 with client #6 revealed: - Staff check her BP weekly - She had not had any low BP readings however she wasn't aware of what would be considered a low BP reading - She hasn't been dizzy or had any headaches - She hadn't refused any doctors appointments Interview on 5/15/18 with staff #1 revealed: - Staff checked client #6's BP once a week - They take the BP readings to the physician for review - She would call the physician if the BP reading was too low - She considered 43/70 would be too low and 180/100 would be too high - Client #6's low BP was discussed with her physician last month and medication changes were made - She attempted to take client #6 to the physician after a recent low reading however	V 291	An appointment has been scheduled with client's Primary Care Physician to discuss the readings and advise on future protocol. However, staff will monitor and observe Blood Pressure readings for the resident and notify the Doctor immediately. QP will monitor on monthly basis to be sure that the staff follows the instructions.	5/22/18

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V 291	Continued From page 4 client #6 refused - She had not notified the physician regarding any of the other low BP readings Interview on 5/18/18 with client #6's Primary Care Physician revealed: - She had not been informed client #6's BP readings were low - The BP readings above concerned her because it meant reduced blood flow - She should have been notified regarding the low BP readings so that other treatment measures could have been discussed Interview on 5/15/18 with the Qualified Professional (QP) revealed: - According to the MAR, staff should have contacted client #6's physician due to the low BP readings listed above - Staff had not contacted client #6's physician within the last 2 months due to low BP readings - A new FL-2 was completed on 4/23/18 and it was not listed on the FL-2 to call physician for low readings therefore it should have been removed from the MAR Interview on 5/18/18 with the Licensee revealed: - Client #6's FL-2 was completed in April and the physician removed the BP parameters off of the FL-2 - She's not sure if the pharmacy updated their system or not to removed it off of the MAR - She would follow up with the physician and the pharmacy to determine if the parameters were needed	V 291		