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		
AND FLAN OF CORRECTION		1521111110/111011110/11102111	A. BUILDING:				
MHL092-919		B. WING		R 02/15/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ALPHA H	OME CARE SERVICES IN	IC	STBORO ROAD LLE, NC 27545				
(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 COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
V 000	INITIAL COMMENTS		V 000				
	on February 15, 2019 This facility is licensed	up survey was completed Deficiencies were cited.  d for the following service 27G .5600A Supervised Mental Illness.					
V 114	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.		V 114				
	failed to ensure disas least quarterly and re findings are: Review on 2/14/19 of for the previous 12 m	ew and interview the facility ter drills were completed at peated on each shift. The  the facility's disaster drills onths revealed: s on the 3rd shift between					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
					R
		MHL092-919	B. WING		02/15/2019
	ROVIDER OR SUPPLIER DME CARE SERVICES IN	1041 HU	DDRESS, CITY, STATI NSTBORO ROAD DALE, NC 27545	E, ZIP CODE	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 114	Continued From page 1  During an interview on 7/14/19, the Qualified Professional reported fire and disaster drills were conducted monthly on each shift. The shifts were:  1st - 7:00am - 3:00pm; 2nd - 3:00pm - 11:00pm 3rd - 11:00pm - 7:00am  During interview on 2/14/19: - client #1 reported she did not remember any disaster drills - client #2 reported fire and disaster drills were done every month		V 114		
V 736	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it maintained in a safe,	EMENTS	V 736		
	Observation on 2/14/  - the storm door and door handle  - there was no lice downstairs bathroom	and interview, the to maintain the facility in a canner. The findings are:  19 at 8:30am revealed: at the front of the facility had to the toilet in the			

Division of Health Service Regulation

STATE FORM 5899 YUNK11 If continuation sheet 2 of 3

PRINTED: 02/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED			
MHL092-919		B. WING			R <b>02/15/2019</b>				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1041 HUNSTBORO ROAD									
7(2) 117(11)	J 07.1112 02.1111020	KNIGHTD	ALE, NC 27545						
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
V 736	Continued From page	2 2	V 736						
7,00	During an interview of Professional reported for the door and toilet left there by a client w	n 2/14/19, the Qualified I she would put in an order I lid. The bags of trash were who was supposed to put must have forgotten before	V 160						
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.							

Division of Health Service Regulation

STATE FORM 5899 YUNK11 If continuation sheet 3 of 3