STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MUI 002 940	B. WING		04/04/0040
		MHL092-819			01/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ALPHA H	OME CARE SERVICES, II	NC IV	NN DRIVE		
	Г	CARY, NO	27511		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual survey was Deficiencies were cite	s completed on 1/24/19. ed.			
	Category 10A NCAC	d for the following service 27G .5600C Supervised ntally Disabled Adults.			
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112		
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
		MHL092-819	B. WING		01/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA HO	OME CARE SERVICES, II	NC IV 613 ELLYN				
		CARY, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	÷ 1	V 112			
	failed to ensure strate address one of three behaviors. The findin Review on 1/23/19 of -Admission date	ew and interviews the facility egies were developed to (#2) audited clients gs are: client #2's record revealed: of 6/10/14 Id Mental Retardation,				
	During interview on 1/23/19 Client #4 stated: -There had been issues at the home with client #2 stealing food from the kitchen. -Client #2 had been taking food from the kitchen at night. -Staff #1 forgot to lock the kitchen and client #2 stole stuff. -Client #2 had taken some of his money from his room and staff #1 had to get on him for that.					
	-Client #2 stole h -Had been lookin -Staff #1 noticed door was open one do bed that matched the -Staff #1 checked was hisClient #2 had the security and ID)Aware client #2	the wallet and realized it rown out all his cards (social had stole food from the to lock the kitchen at night.				
	-Started working	in the home around July				

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-Around September/October 2018 noticed

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		-LETED
		MHL092-819	B. WING	B. WING		/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A 1 D 1 1 A 1 1	NE 04DE 0ED\(\(\text{0E0}\)\	613 ELLY	NN DRIVE			
ALPHA H	OME CARE SERVICES, I	CARY, NO	27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	2	V 112			
	client #2 was going in steal food, lunch mea -Had to start lock him out. -This would occu week for a few month -Client #2 stole of ago. -Client #3 stated and they had looked of -One day saw cliopen and noticed three one matched the design wallet. -At first client #2 later confessed to it. -There had been wallet, things were m	ato the kitchen at night and the kitchen door to keep with a stopped. It is a stopped to keep him is a stop				
	things. -There was an "is stole food from the kit -Staff had only m regarding food. -Not aware of an things from clients. -Not aware the k to client #2 stealing. -Told staff to mor -Ask client #2 to anything he needed. -Told client #2 not Further review on 1/2	ited: ent #2 had been stealing solated" incident where he				

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STATE FORM 6899 LXJW11 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		MHL092-819	B. WING		01/24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			'NN DRIVE	,	
ALPHA H	OME CARE SERVICES, I	NC IV CARY, N			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 3	V 112		
	address stealing food and other clients' personal belongings in the last six months.				
	_	/24/19 the Licensee stated: een with them for many			
	-Never heard of I -The QP would h	him having issues stealing. nave told her if this was going			
	On.	a while back there was an			
		I to lock the kitchen, but			
		were left out for clients.			
	-Will address this				
V 114	27G .0207 Emergeno	cy Plans and Supplies	V 114		
	10A NCAC 27G .020 AND SUPPLIES	7 EMERGENCY PLANS			
	(a) A written fire plan				
	·	an shall be developed and			
	shall be approved by	the appropriate local			
	authority. (h) The plan shall be	made available to all staff			
		edures and routes shall be			
	posted in the facility.				
	(c) Fire and disaster of	drills in a 24-hour facility			
		quarterly and shall be			
	•	ift. Drills shall be conducted			
		simulate fire emergencies. have basic first aid supplies			
	accessible for use.	Trave basic first aid supplies			
	This Dule is not seet	as suideneed by:			
	This Rule is not met	as evidenced by: ew and interview the facility			
	failed to ensure Fire I	•			
	quarterly for each shi				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-819	B. WING		01/2	4/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STATE	E, ZIP CODE		
ALPHA H	OME CARE SERVICES,	INC IV	ELLYNN DRIVE 7, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From pag	ne 4	V 114			
V 512	-"6/19/18- 12:03 -6/28/18-7:15 A -7/29/18-6:00 P -8/23/18-7:00 A -11/2/18- 7:30 F -12/21/18- 5:00 -1/19/19- 7:30 A During interview on -Her staff were drills monthlyThe drills were dayNot aware the conthird shiftWill follow up to on each shift as required.	M M M M M M M M M M M M M M M M M M M	V 512			
	10A NCAC 27D .030 HARM, ABUSE, NE (a) Employees shall abuse, neglect and e with G.S. 122C-66. (b) Employees shall sort of abuse or neg 27C .0102 of this Ch (c) Goods or service purchased from a cli established governin (d) Employees shall necessary to repel o aggressive client and governing body polic is necessary dependent	PROTECTION FROM GLECT OR EXPLOITATION protect clients from harm, exploitation in accordance not subject a client to any lect, as defined in 10 A NCAC papter.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL092-819	B. WING		01/2	24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALPHA H	OME CARE SERVICES, I	NC IV 613 ELLY CARY, NO	NN DRIVE 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 512	and physical and mer of aggressiveness dis intervention procedur Subchapter 10A NCA (e) Any violation by a (a) through (d) of this dismissal of the empl. This Rule is not met Based on record revir former staff (FS#1) st (#3, #4) to abuse. The Review on 1/24/19 of Hire date of 10/2 A. During interview of FS #2 had work ago. FS #2 had threat Client #4 stated and FS #2 began to yhis chores. Client #4 stated whip your a#!." Client #4 stated husband what FS #2 Client #4 stated husband what FS #2 Client #4 stated him he would talk to foose his job for that in Client #4 stated him he would talk to foose his job for him he would tal	as evidenced by: ew and interview one of one diplected two of four clients are findings are: FS's #2 record revealed: ed at the home a few weeks tened him one day. he was sitting on the couch rell at him for not completing FS#2 told him, "I'm gonna he told the Licensee's said to him. the Licensee's husband told FS #2 because he could kind of stuff. he was not aware if the ever spoke to FS #2, but he again. #24/19 The Licensee's e company in maintenance	V 512	DELIGITION)		
		de direct care to clients.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			
MHL092-819		B. WING		01	/24/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
AL DUA U	OME CADE SEDVICES II	NC IV 613 ELLY	'NN DRIVE			
ALPHA H	OME CARE SERVICES, II	CARY, N	C 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From page	e 6	V 512			
	-Did not recall cli FS #2 threatening hin	ent #4 ever telling him about n. d have told him this, he nim to the Qualified				
	B. During interview on 1/23/19 Client #3 stated: -FS #2 worked in the home a few weeks ago, and did not like him. -One day, "I did something he didn't like, so he started following me around the house." -Client #3 stated he walked out the front door to cool off. -FS #2 followed him out the front door saying, "hit me, hit me." -Client #3 stated he did not want to hit FS #2, he just needed to cool off and FS #2 was acting like he wanted him to fight him. -After that, "I got on the phone and called [QP] so he would talk to [FS #2] about it." -The QP told him he would "handle" it, and then they moved FS #2 to a sister facility. -Not sure if QP talked to FS #2, but they just moved him.					
	-He was not awa against FS #2 from th -FS #2 was move middle of December 2 relieve another staff. -FS #2 had work month. -FS #2 had work years ago, with no co	ed to a sister facility in the 2018 due to needing to ed in the home for about a ed for the company five ncerns. d a phone call from client #3 with FS #2 verbally				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-819 B. WING			01/24/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ALPHA HO	OME CARE SERVICES, II	NC IV			
		CARY, NO	27511 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETE
V 512	Continued From page	÷ 7	V 512		
	communicated any in threats made on clien	formation regarding the t #4 by FS #2.			
	-She had not bee	/24/19 The Licensee stated: en made aware of any			
	-FS #2 is no long	at the home with FS #2. er employed with the			
		ntly terminated from a sister ons of verbal abuse towards			
	clients.				
	-No one at the home had mentioned he had threatened or taunted them, "we would have				
	immediately relieved l paperwork HCPR, inc				
	-Client #3 called	her for everything, he had			
	many times in the pas	ne number and had used it st when he was upset about			
	something, so this wa not informed her of th	s surprising he would have ese allegations.			
	-Had constant co	ntact with her QP daily,			
	there had been no me reported to him.	ention of these things			
	Review on 1/24/19 of				
	completed by the Lice revealed:	ensee dated 1/24/19			
	to ensure the safety of	e action will the facility take f the consumers in your			
		question was already			
	on Abuse and Neglec	pany will follow up monthly t training and meetings." ans to make sure the above			
	· ·	meet with all the residents			
		cerns. The QP will meet apliance with company			
	•				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL092-819	B. WING		01/	24/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ALPHA H	OME CARE SERVICES,	INC IV	YNN DRIVE IC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 512	Clients #3, and #4 in health diagnoses inc Mild Intellectual Disa threatening language fight in saying to clien physical intimidation threatening posture of telling another client when arguing with clicompleted during his at this facility. Clients other employees of thappening. This type serious abuse. The varule violation and mudays. If the violation days, an additional a \$200.00 per day will	the group home had mental lusive of Schizophrenia, and	V 512			
V 736	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and i maintained in a safe, manner and shall be odor. This Rule is not met Based on observatio failed to maintain the attractive manner an offensive odor. The	REMENTS its grounds shall be clean, attractive and orderly kept free from offensive as evidenced by: n and interviews the facility home in a safe, clean, d shall be kept free from	V 736			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL092-819	B. WING		01	/24/2019
	ROVIDER OR SUPPLIER	613 ELLY	DDRESS, CITY, STA	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 736	following: -Client #4's mattr areas of indention's ir -Client #3 and #4 body odor. -Vacant client roc indented in the middle -The downstairs: During interview on 1. -There used to be with issues urinating or recently removed all carea. -Client #4 had hy and wearing clean cloents that were to be -Staff #1 is a very cleaned the house a lient strate.	ress was worn and showed in the middle. It's room had a very strong om mattress was worn and exarea had a strong body odor. It's a client in the downstairs on the floor and they had carpet and deep cleaned the regiene issues with bathing othes. In the mattresses for several example delivered Saturday. It's good house keeper,	V 736			

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