STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-921	A. BUILDING: _____ B. WING _____	R 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	1037 WHETSTONE COURT RALEIGH, NC 27615

(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 9, 2019. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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.	V 291	The resident was able to meet with the doctor after several refusals and nothing was wrong with the palms. However, the QP will continue to monitor him weekly. The bandage was behavioral as there was no sprain on his palms. 7/8/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JAMES COMBS BS QP/MANAGER — TITLE — (X6) DATE: 07/08/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-921	A. BUILDING: _____ B. WING _____	R 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	1037 WHETSTONE COURT RALEIGH, NC 27615

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V 291	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to coordinate services between facility operator and other qualified professionals responsible for one of four audited client's (#4) system of care. The findings are Observation on 04/11/19 at 4:00 PM revealed client #4 in the house and a bandage wrapped on his left hand. Unsuccessful attempts between 04/11/19 and 05/09/19 were made to interview client #4 as he refused Review on 04/11/19 , 04/16/199 of client #4's record revealed the following: -admitted: 07/20/18 -diagnoses inclusive of Traumatic Brain Injury, Schizophrenia, Leukopenia and Gastroesophageal Reflux Disease -no notes or documentation regarding treatment or services of the hand -no notes or documentation regarding client's refusal A. Review on 05/09/29 a not dated document provided by the Qualified Professional (QP) revealed he wrote a note indicating client refused treatment. During interviews between 04/11/19 and 05/09/19, the QP reported about client #4: -did not recall when the issue with client #4's hand was initially noted...estimated a few weeks before April 11, 2019 -refused to go to hospital said it was no pain.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-921	A. BUILDING: _____ B. WING _____	R 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	1037 WHETSTONE COURT RALEIGH, NC 27615

(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 2 -initially it was on left hand, then he did it on the right hand that needed to be wrapped. -said he didn't sprain right hand but loved feeling of bandage. -around April 8-9, 2019 he noticed the left hand wrapped with bandage ...client #4 someone gave him the bandage...client #4 reported the person was a former resident. -"we don't have a medical expert saying whether it was sprain or not." B. Review on 04/11/19 of the North Carolina Incident Reporting Improvement System revealed the following entry on 04/07/19: "At about 10am on Sunday April 7, 2019, [client #4] signed himself out and left the group home to take a walk within the neighborhood. He did not return as expected. For his safety, staff called Raleigh Police for assistance. Police visited the group home and obtained his information. [Client #4] returned to the group home about 4pm same day. Staff called and notified Police Department of his return. An Officer came to the house to verify his return and his name was removed from missing persons list." During interview on 05/09/19, the QP reported the following about client #4: -in reference to the 04/08/19 elopement, agency had a discharge notification for 60 days should he refuse therapy and other services. -since 04/08/19, he had not gone to therapy sessions because his therapist office was merging with another therapist's office -the next scheduled appointment was 05/24/19 but they were not sure of when the transition was effective -agreed to go to the next therapist appointment	V 291	Resident was issued a 60 day notice of discharge and we are in the process of securing a legal Guardian for him. Hearing has been scheduled. QP will continue to monitor him weekly until he leaves.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
MHL092-921	A. Building B. Wing	5/9/2019

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME CARE SERVICES INC	1037 WHETSTONE COURT RALEIGH, NC 27615

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 V0105 Reg. # 27G .0201 (A) (1-7) LSC	Correction Completed 05/09/2019	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR India Vaughn-Rhodes	DATE 5 9 19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/7/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: OJMX12

STATE FORM: REVISIT REPORT (11/06)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 25, 2019

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

Re: Annual and Follow Up Survey completed May 9, 2019
Alpha Home Care Services, Inc., 1037 Whetstone Court, Raleigh, NC 27615
MHL # 092-921
E-mail Address: juliet@alphahealthservices.com

Dear Juliet Okwoshah:

Thank you for the cooperation and courtesy extended during the Annual and Follow Up Survey completed May 9, 2019.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is July 9, 2019.

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,

India Vaughn-Rhodes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant