

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-749</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/17/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALPHA HOME CARE SERVICES INC II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4517 WATERBURY ROAD</b> <b>RALEIGH, NC 27604</b>
--	---

(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 and Follow Up Survey was completed on October 17, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ul style="list-style-type: none"> <li>(1) the client's presenting problem;</li> <li>(2) the client's needs and strengths;</li> <li>(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;</li> <li>(4) a pertinent social, family, and medical history; and</li> <li>(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.</li> </ul> <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p>	V 111		

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:  <b>MHL092-749</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/17/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALPHA HOME CARE SERVICES INC II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4517 WATERBURY ROAD</b> <b>RALEIGH, NC 27604</b>
--	---

(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 111	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure an assessment was completed for one of three clients ( #5). The finding is:</p> <p>Review on 10/15/19 of client #5's record revealed:</p> <ul style="list-style-type: none"> <li>-Admitted: 08/14/19</li> <li>-Diagnoses: Intellectual Developmental Disability, Depressive Disorder, Anxiety Disorder and Schizophrenia</li> <li>-Incomplete assessment dated 08/30/19 not inclusive of the client's presenting problem, needs and strengths, pertinent history (social, family, medical), evaluations or assessment (such as psychiatric, substance abuse, medical, and vocational) as appropriate to the client's needs</li> </ul> <p>During interview on 10/16/19, the Qualified Professional reported:</p> <ul style="list-style-type: none"> <li>-Client #5 came from a setting in another state. She was relocated to North Carolina to a least restrictive environment from the state operated hospital setting.</li> <li>-When client #5 was admitted, evaluations etc were requested but had not been received.</li> <li>-He was aware of the information required to complete a full assessment but was not able to explain why it was not included in the admission process and/or assessment.</li> </ul>	V 111		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-749</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/17/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ALPHA HOME CARE SERVICES INC II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4517 WATERBURY ROAD</b> <b>RALEIGH, NC 27604</b>
--	---

(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 2</p> <p><b>EXTERIOR REQUIREMENTS</b> (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to assure the facility was maintained in an orderly manner. The findings are:</p> <p>Observation on 10/16/19 between 11AM-2PM revealed the following:                      -Upstairs bathroom- curtain rod rusted, circular brown stains/spots on the ceiling                      -Upstairs client bedroom (single occupant) on right- disconnection noted between wall and ceiling causing a crack                      -Second upstairs client bedroom (single occupant) on right- two circular spots on the ceiling, one noted near the fire alarm                      -Upstairs hallway- light switch plate cracked                      -Stairway leading to downstairs- hanging wired noted                      -Downstairs laundry room- circular stains noted on ceiling</p> <p>During interview on 10/17/19, the Qualified Professional reported:                      -He would discuss with the Licensee and have maintenance resolve the identified violations</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736		