

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
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NAME OF PROVIDER OR SUPPLIER
ALPHA HOME CARE SERVICES, INC IV

STREET ADDRESS, CITY, STATE, ZIP CODE
**613 ELLYNN DRIVE
CARY, NC 27511**

(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
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V 000 INITIAL COMMENTS

An annual survey was completed on 1/23/20. A deficiency was cited.

V 000

DHSR-Mental Health
JAN 30 2020
Lic. & Cert. Section

This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.

V 736 27G .0303(c) Facility and Grounds Maintenance

V 736

10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS
(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.

The mattress for client #1's bedroom has been replaced. QP will continue to monitor and ensure that the facility and its grounds are maintained in a safe, clean, attractive and orderly manner on a monthly basis.

This Rule is not met as evidenced by:
Based on observation and interview the facility failed to maintain the home in a safe and attractive manner. The findings are:

Broken washing machine, discarded mattress and television have been removed from downstairs hallway.
QP will continue to observe the home on a monthly basis to ensure it's free of any debris.

Observation on 1/23/20 at approximately 11:05am of the facility revealed the following issues:
-Client #1's bedroom mattress was indented in the middle the size of extra large ball.
-Downstairs hallway filled with broken washing machine, discarded mattress, and discarded 37 inch television which made it difficult to walk through to other rooms.

Interview on 1/23/20 at approximately 11:10am staff #1 reported:
-Client #1's mattress was just replaced.
-Does need a new mattress.
-Items have been in the hallway 3 or 4 weeks

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

JAMES SORBER

TITLE
QP/MANAGER

(X6) DATE
01/30/2020

Division of Health Service Regulation

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V 736	<p>Continued From page 1</p> <p>maybe.</p> <p>-Waiting on maintenance man to come and remove old items from the hallway.</p> <p>Interview on 1/23/20 at approximately 3:00pm Qualified Professional reported:</p> <p>-Will replace client #1's mattress.</p> <p>-Maintenance will come remove those items from the downstairs hallway.</p>	V 736		



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

1/29/2020

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

DHSR-Mental Health

JAN 30 2020

Lic. & Cert. Section

Re: Annual Survey completed 01/23/2020
Alpha Home Care Services, Inc. IV, 613 Ellynn Drive, Cary, NC 27511
MHL # 092-819
E-mail Address: juliet@alphahealthservices.com

Dear Ms. Okwoshah:

Thank you for the cooperation and courtesy extended during the annual survey completed 01/23/2020.

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 03/23/20.

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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

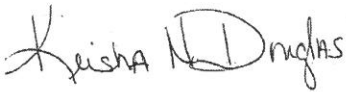
01/29/2020
Juliet Okwoshah
Alpha Home Care Services, Inc. IV

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 at 919-552-6847.

Sincerely,



Keisha N. Douglas
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

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