Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	OF CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COWILL	1120
		MHL092-749	B. WING		08/2	5/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
АТ ВЫА Ы	OME CARE SERVICES IN	4517 WATE	RBURY ROAD)		
ALPHA III	OIVIE CARE SERVICES II	RALEIGH,	NC 27604			
(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	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	The complaints were #NC00167250, #NC0 #NC00166206). A de This facility is license category: 10A NCAC					
V 291	27G .5603 Supervise	d Living - Operations	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.					

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

(X6) DATE TITLE

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DIVISION	n nealth Service Negu	ialion			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED
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		MHL092-749	B. WING		08/25/2020
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4517 WAT	ERBURY ROAD)	
ALPHA H	OME CARE SERVICES IN	IC II RAI FIGH	NC 27604		
			1.10 2.00		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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IAG	TREGOEMION ON E	iso ibentili tino ini onim moni	TAG	DEFICIENCY)	
				,	
V 291	Continued From page	e 1	V 291		
	or legal system is invo	olved or when health or			
	safety issues become	e a primary concern.			
	This Rule is not met	as evidenced by:			
		ew and interview, the facility			
		•			
		ervices with other qualified			
		sible for the care for one of			
	one former clients (#1	I0). The findings are:			
	Review on 07/23/20-08/06/20 of Former Client				
	(FC) #10's record rev	ealed:			
	-Admitted: 12/05/	/09			
	-Discharged: 06/2				
	_	Intellectual Disability			
	-Age: 60	intellectual Disability			
	•				
	-Served as own (
		20 Monthly weights			
		nome staff: January 15-			
	(170); February 8-(17	70); March 11-(160); April			
	14-(168); May 3-(150	0)			
	Review on 08/06/20 o	of FC #10's record			
	maintained by her Pri	mary Care Physician (PCP)			
	revealed the following	, ,			
	February 25, 2020-Ju				
	_				
		pe of Visit: In person			
	Weight:				
	•	and Physical report: c/o			
	(complains of) left kne				
		ment/Plan: Continue with PT			
	(Physical Therapy)				
	-03/03/20- Typ	oe of visit: In personPhysical			
	exam				
		(not documented)			
		and physical report: Lab			
	Order only and Physic				
	Assessr	ment/Plan: "Reviewed			

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exellent labs with patient. Excellent job on weight

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AL DUA II	OME CARE CERVICES IN	4517 WATE	RBURY ROAD			
ALPHA H	OME CARE SERVICES IN	RALEIGH,	NC 27604			
(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 APPROPR DEFICIENCY)	BE COMPLET	Έ
V 291	Continued From page	2	V 291			
V 231	lossGoal weight 168 -05/08/20: Typ (Telephone Encounte	pe of Visit: Telehealth r) not referenced and Physical Report: Acute ght shoulder painFC #10 PT due to COVID-19 rge family of viruses that are rs ranging from the common diseases). Never seen rays of knees or shoulder. rinjured her knees 10 years Pain reported during her knees caps felt "stiff." ment/Plan: "Application of Ice concern reviewed"follow provement re of Visit: Referral Order and Physical Report: Acute ment/Plan: Referred to re of Visit: In person 149.2 63 inches (5 feet 3 inches) and physical Report: oss, constipation, edema of Abdominal pain ment/Plan:"Concerning wright loss and edemawill I need CT imaging to further	V 251			

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Review on 07/31/20 of the Orthopedic Service

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ALPHA H	OME CARE SERVICES IN	NC II	TERBURY ROAD			
		RALEIGH	I, NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 291	Continued From page	e 3	V 291			
	following: -PCP referral da' Referral information i FC #10 fell at a bask Treatments included medications. Pain sui medication. Flare up prescribed "last mont Review on 08/07/20 of the PCP and the OSF revealed the following -05/26/20- PCP si -05/28/20- OSP client, unable to leave number provided	bsided while on pain noted with a medication th." of Communication between P submitted by the PCP g: submitted referral to OSP noted attempted to reach the message, no other phone				
	Appointment" dated (facility's Qualified Pro"Phone visit with Prin"#10's] weight loss, kninformed doctor of [Fipains. Doctor prescril" A. During interview book/13/20, staff #1 rep#10's weight loss: -She visited her holidays. During the vagreement to pay helfamily wanted her to Between March food. In May, she was	etween 08/04/20 and corted the following about FC family in 2019 around the visit, her mom had an r \$50 if she lost weight. Her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
AL DUA U	OME CARE SERVICES IN	4517 WAT	ERBURY ROAD		
ALPHA H	OME CARE SERVICES IN	RALEIGH	, NC 27604		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 291	Continued From page	: 4	V 291		
V 291	wouldn't say she was she looked. [FC #10] That was [FC #10]'s of told [FC #10] she didrig down to 150 pounds. asked to be paid the Survey and to pay her her money appointment was to a pain/swelling in her known and to pay her her money appointment was to a pain/swelling in her known and to pay her her money appointment was to a pain/swelling in her known and to be was presentall. She did not discut during the 05/08/20 Tole During interviews between 15/20 and the control of the cont	sick, but I didn't like the way liked the way she looked. It was she looked. It look good. If C #10] got she called her mother and \$50." The found out she lost weight, own and called her parents." The purpose of the ddress constipation, nees/shoulder not for weight the during the entire Telehealth ass weight loss with the PCP elehealth appointment. The purpose of the ddress constipation, nees/shoulder not for weight the during the entire Telehealth ass weight loss with the PCP elehealth appointment. The purpose of the ddress constipation, nees/shoulder not for weight the same shoulder not for weight the same shoulder not for weight loss weight loss with the PCP elehealth appointment. The purpose of the ddress constipation, nees/shoulder not for weight loss weight loss weight loss over a libs would not be drastic. If 20 pounds in a month, don the individual, I am not low how much an average	V 291		
	#10 was seen by an a in the absence of her -During the 05/08 there was no mention	associate PCP at the office			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7 t. BOILBING.		С		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALPHA H	OME CARE SERVICES IN	IC II	RBURY ROAD)		
		RALEIGH,	NC 27604			
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 291	Continued From page	÷ 5	V 291			
	-During the 06/08 look well or like herse doctor mentioned to r during that visit and the bowel movement was appointment. Anemia diet. Labwork would refer well and refer week. -FC #10's weight Anemia -A healthy weight pounds per week. During interviews bett 08/13/20, FC#10 reported in an oper service of parents that if she los money.	2/20 visit, "Visually, she didn't lif in passing." The other ne about the weight loss ne constipation. Her last a week prior to the May and constipation due to the lave been completed loss may have caused the t loss consisted of 1-2 ween 07/27/20 and orted she had not:				
	During interviews between 07/31/20 and 08/14/20, FC #10's employment specialist reported she: -Assisted FC #10 at work prior to January 2020. -Visited FC #10 at her work location or communicated with her via Telehealth twice a month on average. -Had never heard FC #10 discuss weight loss or an ongoing monetary incentive from her family to lose weight B. During interview on 07/28/20, FC #10's Physical Therapist reported: -She had received office visit services between January-March 2020 due to pain in her lower back and knees. -FC #10 decided due to COVID-19 and the stay at home orders, she wanted to suspend her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		MHL092-749	B. WING		08	C 3/ 25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AL DUA III	OME CARE CERVICES	4517 WA	TERBURY ROAD			
ALPHA H	OME CARE SERVICES I	RALEIGI	H, NC 27604			
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 291	Continued From pag	e 6	V 291			
	for her.	xercises were recommended staff was present during her				
	-A Group home staff was present during her sessions. During interviews between 08/04/20 and 08/13/20, staff #1 reported the following about FC #10: -Telehealth Appointment on 05/08/20: The purpose of the appointment was to address constipation, pain/swelling in her knees/shoulder not for weight loss. "I called twice but it was for her pain." Staff #1 initiated the call about the pain. The QP was not there when I called. She came later on and took her to pick up the prescription. I can't recall if it was the same day." -PT: She attended PT sessions until April 2020. She stopped attending due to COVID-19. During COVID-19, the group home residents exercised three days a week by walking. She did not agree to walk or participate. She came outside and watched others. Her legs were swollen and she c/o pain. -OSP: No appointment had been established before she was discharged from the group home.					
	(worked at a local re -Due to restriction between March-May not allow visitors -FC #10's birthd group home allowed -No in person appeen made for FC # visitDuring the June	ister reported: her sister was "active" staurant, exercised) ons because of COVID-19, 2020, the group home did ay was in early June. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AL DUA III	014E 0 4 DE 0ED\#0E0 #	4517 WA	TERBURY ROAD			
ALPHA H	OME CARE SERVICES II	NC II RALEIG	H, NC 27604			
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V 291	OF PROVIDER OR SUPPLIER A HOME CARE SERVICES INC II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 291	DEFICIENC	Y)	
	group home did addr	ointment on 05/08/20: The less with the PCP the matter lyas concerned the PCP did				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
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ALPHA H	IOME CARE SERVICES IN	IC II	I, NC 27604		
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V 291	Continued From page	÷ 8	V 291		
	weight loss in her not -Coordination wit used one phone for b client was on the tele telephone line, the inc received. Review on 08/20/20 c 08/21/20 submitted b Manager revealed: -"What will you in above rule violations from further risk or ac COVID-19, we have c coordination of servic The facility automatic monthly and will conti mental and medical in reported to their vario accordingly. The staff coordination of reside -Describe your p	QP would have noted the es. th OSP: The group home oth clients and staff. If a phone and did not switch the coming call would not be of a Plan of Protection dated by the facility's Functional contents and the end of the facility's Functional contents and the end of the residents and will continue to do so, ally weighs all residents nue the same process. All the eds of the residents will be end of the residents will be end of the residents will be end of the residents will be us licensed providers are trained on the end of the resident will monitor the end of the professional will monitor.			
	Between April-June 2 decline in her physica	020, FC #10 experienced a il health such as swelling of es and changes in eating			
	Telehealth appointme log noted a decrease loss was not discusse appointment only the swelling were noted. care of the client's co detrimental resulting as labwork to confirm	ont, a monthly facility weight of 18 pounds. The weight ed during her Telehealth pains to her back, legs, and The failure to coordinate mplete health status was in a delay of resources such diagnoses of Anemia based all mobility and functioning			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE COMP		
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	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA ERBURY ROAL NC 27604		<u> </u>	
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V 291	the lack of coordination OSP was not establist been discharged from deficiency constitutes must be corrected within is not corrected within penalty of \$200.00 pe	daily living were impacted by on of care with the OSP. The hed until after the client had a the group home. This a Type B rule violation and thin 45 days. If the violation a 45 days, an administrative or day will be imposed for so out of compliance beyond	V 291			

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