Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	MHL091-109		B. WING	·····	11/05/2020	
	PROVIDER OR SUPPLIER	STATE, ZIP CODE IUE 537				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
V 000	INITIAL COMMENT	ΓS	V 000			
	A follow up survey was completed 11/5/20. Deficiencies were cited. This facility is licensed for the following service					
	category: 10A NCA Living for Adults wit	AC 27G .5600A Supervised h Mental Illness.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR					

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

TITLE (X6) DATE

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		MHL091-109	B. WING		11/	05/2020
	PROVIDER OR SUPPLIER	CES-OAKLAND 2103 OA	DDRESS, CITY, S KLAND AVEN SON, NC 275	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	interview the facility medication to one of	et as evidenced by: on, record review and refailed to administer of three audited clients (#1) on a physician. The findings are:				
	3/17/20 revealed: - admitted 1/27/1 - diagnoses of S Cocaine Use Disord - physician's order mcg twice day & Cl	chizoaffective Disorder &				
	medication box reviews for anxiety) - Clotrimazole 19 skin infections) - Albuterol 90 mo	ot in the medication box (used twice a day (used to treat cg twice a day (used to preven preathing, wheezing and	t			
	September & October MAR- Albuterol were transinitials for the entire - August & September 2	of client #1's August, per 2020 MAR revealed: Chantixm, Clotrimazole & scribed as PRNno staff e month ember 2020 MAR-Chantix ice a daystaff initialed as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL091-109		B. WING		11/0	05/2020
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ALPHA F	AI PHA RESIDENTIAL SERVICES-OAKLAND			(LAND AVEN SON, NC 27:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2		V 118			
V 119	Clotrimazole as req - copy of a medic not visible) twice da During interview on reported: - Medications sha are discontinued. [This deficiency cor and must be correct	culation (DHSR) for cuterol, Chantix and uesteddated 10/1 cation label for Chanty with meals 11/5/20 the Supervould be administered estitutes a re-cited of the days.	client #1 d 15/20" ntix -(mg visor ed until they deficiency]	V 119			
V 119 27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.							

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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	
		MHL091-109	B. WING		11/	05/2020
NAME OF I	PROVIDER OR SUPPLIER	STREE ⁻	ADDRESS, CITY, S	STATE, ZIP CODE		
ALPHA F	RESIDENTIAL SERVIC	CFS-OAKI AND	OAKLAND AVEN ERSON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 119	(4) Upon discharge remainder of his or disposed of prompt expected that the p to the facility and in drug supply shall no	ge 3 of a patient or resident, the her drug supply shall be ly unless it is reasonably atient or resident shall return such case, the remaining of be held for more than 30 the date of discharge.	V 119			
	interview the facility were disposed of in diversion or accider audited clients (#1 and Review on 11/5/20 revealed: - prescription memethods of disposatransfer of medicati	on, record review and realled to ensure medication a manner that guards againtal ingestion for two of three \$\cdot\{\pi}\). The findings are: of the facility's disposal policedicationsacceptable al include the following: on to a local pharmacy	nst e			
	3/17/20 revealed: - admitted 1/27/1 - diagnoses of S Cocaine Use Disord Review on 11/5/20 Health Service Reg revealed: - "discontinue All requesteddated 1	chizoaffective Disorder & der of a fax to the Division of ulation (DHSR) for client #1 outerol and Clotrimazole as 0/15/20" 28/20 at 3:11pm of client #1	d's			

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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. BUILDING.			
M	HL091-109	B. WING		11/05/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALPHA RESIDENTIAL SERVICES-OAK	(I AND	LAND AVEN SON, NC 27			
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTII	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 119 Continued From page 4 - Clotrimazole 1% twice a skin infections) - Albuterol 90 mcg twice and treat difficulty breathing shortness of breath) B. Record review on 11/3/20 dated 5/7/20 revealed: - admission date of 3/7/1 - diagnoses of Schizoaffe Diabetes, Hypertension and Observation 10/28/20 at 2:5 medication box revealed: - a Ziploc bag with appropills with no label Review on 11/5/20 of a fax revealed: - "Effective 10/12/20, [clied discontinue Fenofibrate" (catcholesterol) During interview on 10/28/2 - the medication in the Ziffenofibrate: - client #6 refused the Festival the medication catcholesterol - the physician discontinues he was waiting for the Company of the Company o	a day (used to prevent g, wheezing and 0 of client #6's FL2 9 ective Disorder, d Asthma 58pm of client #6's eximately 11 white oval to DHSR for client #6 ent #6] can an lower high 0 staff#1 reported iploc bag was enofibrate used him not to feel used the medication Qualified Professional o with the pills ere in the bag the Supervisor after surveyor left	V 119			

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		MHL091-109	B. WING		11/0	05/2020
	PROVIDER OR SUPPLIER	SES-OAKLAND 2103 OAF	DRESS, CITY, S KLAND AVEN SON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 119	Continued From pa	ge 5	V 119			
	clients medication but the local pharm discontinued medic	acy would come pick up the				
V 513	27E .0101 Client Ri Alternative	ghts - Least Restictive	V 513			
	that promote a safe These include: (1) using the appropriate settings (2) promoting skills that are altern self or others; (3) providing meaningful to the city sharing of the client/legally results (b) The use of a reprocedure designed always be accompainsure dignity and reintervention. These (1) using the and	all provide services/supports and respectful environment. least restrictive and most and methods; coping and engagement atives to injurious behavior to choices of activities lients served/supported; and control over decisions with sponsible person and staff. Strictive intervention to reduce a behavior shall anied by actions designed to espect during and after the				
	failed to promote a	et as evidenced by: on and interview the facility least restrictive environment £2, #3, #4 & #6) clients . The				

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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 I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALPHA F	RESIDENTIAL SERVIC	CES-OAKLAND	LAND AVEN			
()(1) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON.	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 513	Continued From pa	ge 6	V 513			
	facility's refrigerator - a chain & lock of - variety of food i During interview on - he was Ok with refrigerator - clients stole fro - he didn't know of the refrigerator - clients asked so from the refrigerator During interview on of the staff got what he refrigerator	on the refrigerator. In the refrigerator and freezer 10/28/20 client #1 reported: the lock being on the m the refrigerator who the clients were taff to get what they needed				
	 he stay hungry During interview on 10/28/20 staff #1 reported: clients went in the refrigerator in the middle of the night for snacks he had found a can of bean and franks in the bathroom the chain and lock was on the refrigerator when he came in September 2020 During interview on 11/5/20 the Supervisor reported: the lock and chain were immediately removed from the refrigerator after the surveyor left client #6 ate raw foods from the refrigerator staff now made hourly checks for closer supervision due to lock and chain being removed 					
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	CES-OAKLAND	2103 OAK	DRESS, CITY, S LAND AVEN SON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe	0 03 LOCATION AND	e nd orderly	V 736			
	governing body faile maintained in a safe manner. The finding Observation on 10/3:39pm revealed the client #1 and downstairs there was sever carpet black stains the carpet client #6's bedrethroughout carpet client #2 & #3's same condition During interview on due to COVID (been hard to get so	on and interviews, the doto ensure the facile, clean and attractives are: 28/20 between 3:35	lity was /e om and e ghout s hallway ck stains s in the ported: se) its carpet.				
	During interview on Supervisor reported the carpet was	10/29/20 & 11/5/20 d: cleaned in 2019 management didn't					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COME	(X3) DATE SURVEY COMPLETED	
		MHL091-109	B. WING		11/0	05/2020
	PROVIDER OR SUPPLIER	2103 04				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 736	anyone in the facilit - she was able to 10/30/20 [This deficiency cor	ge 8 y for the safety of the clients o get the carpet cleaned on estitutes a re-cited deficiency sted within 30 days.]	V 736			

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