Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED		
		A. BUILDING.					
MHL092-749		B. WING		01/0	5/2022		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALPHA H	HOME CARE SERVICE	ES INC II		ERBURY RO , NC 27604	DAD		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CIENCIES EDED 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 000	INITIAL COMMENT	ΓS		V 000			
	An annual and comon 1/5/22. The comon 1/5/22. The comon (intake #NC001834) This facility is licens category: 10A NCA Living for Adults with the survey sample	plaint was sub 38). Deficience sed for the follo C 27G .5600Ch Developmen	ostantiated cies were cited. owing service C Supervised ntal Disabilities.				
current clients, 1 former client.							
V 118	27G .0209 (C) Med	ication Requir	rements	V 118			
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 administering the drug.							

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
MHL092-749		B. WING		01/0	5/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1		
ALPHA I	HOME CARE SERVICI	ES INC II	ERBURY RO	DAD			
0.0.15	CLIMMA DV CTA		, NC 27604	DDOWDEDIC DLAN OF CODDECT	ON	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 1	V 118				
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation					
	interviews the facilimedications as ord of 3 audited clients. Review on 1/04/22 - Admitted 6/19/21 - Diagnoses: Bipola autism Spectrum Disorder in remissic - Physician's orders - Hydroxyzine Pamone capsule by mouth it additional capsule a anxiety (for anxiety Review on 1/04/22	view, observation and ty failed to administer ered by a physician affecting 2 (#2 ). The findings are: client #4's record revealed: ar Disorder, unspecified, isorder and Cannabis use on a signed 11/10/21 50 milligrams (mg) - Take on the afternoon may take at bedtime as needed for (*) of client #4's MARs for					
	October 2021 - Jan - There were no tra Hydroxyzine 50 mg	uary 2022 revealed: nscriptions on the MAR for to be administered an at bedtime as needed dose					
	MAR	2 staff #1 reported: medications as written on the sent to the pharmacy and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL092-749		B. WING		01/0	5/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALPHA I	HOME CARE SERVIC	FS INC II	ERBURY RO , NC 27604	DAD		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 2	V 118			
	printed on the MAR - Doesn't understar mistake	t and how the pharmacy made a				
	reported: - She hadn't checke - The script had reamedication 2 times	2 the Qualified Professional ed the MAR ad that client #4 was to get the a day and as needed e pharmacy to ask about the				
	Review on 1/04/22 of client #2's record revealed: - Admitted 8/06/14 - Diagnoses: Major Depressive Disorder, Mild Mental Retardation, Seizure Disorder, Dysthymia and Generalized Anxiety - Physician's orders signed 10/17/20 - Tamsulosin HCL 0.4 mg capsule- Take one capsule by mouth once daily 30 minutes after dinner (urinary issues)					
	October 2021 - Jar	of client #4's MARs for uary 2022 revealed: itialed as being administered ter dinner				
	revealed: -Tamsulosin was n	4/22 of client #2's medications of present in the pre-package medications from January 4 the month				
	She had not obse pre-packaged packThe pharmacy wo pill was missing	d medication technician rved the pill missing from the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
MHL092-749		B. WING		01/0	05/2022		
AL PHA HOME CARE SERVICES INC II			DRESS, CITY, S ERBURY RO , NC 27604	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	was missing - Had not checked of pre-package packer Interview on 1/04/22 reported she: - Had been working - Had not checked - Agreed the medic pre packaged pack - Would call the phase added to the packer Due to the failure to medication administ determined if clients as ordered by the pre-	the MAR against the MAR against the from the pharms of the Qualified Properties of the Qualified Properties of the medications of the medications of the pharmacy to have the theory of the pharmacy to have the pharmacy to have the theory of the pharmacy to have the pharmacy the pharmacy to have the pharmacy the pharmacy to have the pharmacy the pharma	ofessional ce June 2021 or the MAR g from the nacy ne medication ment of be nedications	V 118			
V 736	27G .0303(c) Facilii 10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saft manner and shall b odor. This Rule is not me Based on record re observation, the fact was maintained in a attractive manner. Review on 1/04/22 maintained by the E	et as evidenced by view, interview ar clean, safe, order findings are:	ND I be e and orderly offensive y: nd ure the home erly and blic record	V 736			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL092-749		B. WING		01/05/2022		
			DRESS, CITY, S	STATE, ZIP CODE	•	
ALPHA I	HOME CARE SERVIC	ES INC II	ERBURY RO , NC 27604	DAD		
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V 736	Regulation revealed report dated 10/15/following: - 15 demerits identitientities identities identit	d a local Sanitation Inspection 21 which included the fied used only once" rawer pull on bottom cabinetry igerator) sharp screw drawer " the bath tub and flooring (in om) ed and in poor repair" client's bedroom broken" the abedroom that has been 4/22 at 1:00PM revealed: broken with screw protruding rator lid not worked athroom cracked the length of the tile attached from the wall om mattress had an indention tball the bedroom #3 to out of 2 cover m #4 ottom drawer idention the size of a soccer	V 736			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-749	B. WING		01/0	05/2022
NAME OF				CTATE ZID CODE	1 01/0	3/2022
	PROVIDER OR SUPPLIER	4517 WA	ERBURY RO	STATE, ZIP CODE DAD		
ALPHA I	HOME CARE SERVICE	S INC II	, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 736	of the dresser was a the drawer handle we loosely by one screen. Interview on 1/04/22. Her mattress was a survey. She had asked the to replace her mattresurvey. She doesn't know out in the bathroom. There hadn't been bulbs in her bathroom. Interview on 1/04/22. There was a dent in the dresser had be home, been living a survey.	ken drawers out of 4, the face slanted off the drawer base, was broken and hanging w. 2 with client #2 reported: uncomfortable Qualified Professional (QP) ress the week prior to the how long the light has been in her bedroom any covering over the light	V 736			
	-She had noticed so replaced -She had not notice -She would ensure addressed	ome mattresses needed to be d the broken dressers everything noted would be cited 2 times on 10/17/19 &				

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