` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
				R					
MHL092-791			B. WING	3. WING 02					
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE					
ALPHA HOME CARE SERVICES, INC III 3716 ARROWWOOD DRIVE									
AEI IIA I	IOME OAKE CERTIC	RALEIGH	I, NC 27604						
(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)	D BE	(X5) COMPLETE DATE			
V 000	INITIAL COMMENT	rs	V 000						
	completed on 2/7/2	nt and follow up survey was 2. Intake #'s (NC 00184864, e substantiated and ited.							
		sed for the following service C 27G .5600A Supervised h Mental Illness.							
	The survey sample clients.	consisted of three current							
V 118	27G .0209 (C) Medication Requirements		V 118						
	only be administered order of a person andrugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included and individual of the privileged to prepare (4) A Medication Adrall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength,	inistration: non-prescription drugs shall and to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept and administered shall be ely after administration. The ne following:							
	(D) date and time the	administering the drug; ne drug is administered; and of person administering the							

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			R/SUPPLIER/CLIA ATION NUMBER:	` '			SURVEY PLETED		
							R		
		MHL09		B. WING		02/0	07/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  2746 ARROWMOOD DRIVE									
ALPHA HOME CARE SERVICES, INC III  3716 ARROWWOOD DRIVE RALEIGH, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE		
V 118	drug. (5) Client requests checks shall be red file followed up by a with a physician.  This Rule is not me Based on record re	for medication corded and ke appointment of a sevidence wiew and inte	ept with the MAR or consultation  ed by: rview the facility	V 118					
	failed to ensure one medications were a order of a physician Review on 2/3/22 of Admission date of Diagnoses of Boro Attention Deficit with (ADHD) and Mild In Disability.	administered on. The finding of client #2's re 7/13/19 Ierline Person th Hyperactivit	on the written gs are: ecord revealed nality Disorder, ty Disorder						
	Review on 2/3/22 of dated 11/2/21 revealed 11/2/21 revealed no 2/3/22 of Review on 2/3/22 of Record (MAR) revealed no Flutica	aled: 0 mg-one spr  of Medication realed staff #6' o as administed of client #2's means and presented staff	Administration s initials beside ered. nedications sent.						
	Interview on 2/3/22 -He had administer Pro that morning.								

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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		
MHL092-791		B. WING			R <b>02/07/2022</b>			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ALPHA HOME CARE SERVICES, INC III  3716 ARROWWOOD DRIVE RALEIGH, NC 27604								
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 118	Continued From page 2			V 118				
	-Attempted to locate it in the trash and could not find itNot sure when the refill will be delivered.							
V 736	27G .0303(c) Facility and Grounds Maintenance			V 736				
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	REMENTS I its grounds sh e, clean, attract	all be ive and orderly					
	This Rule is not me Based on observati failed to ensure the clean and attractive Observation on 2/3	on and intervie home was mai manner. The /22 at 11:30 AM	w the facility ntained in a findings are: I revealed					
	-Floor throughout th -The toilet in client feces on top of sear -Multiple light bulbs missing.	#2 and #3's bat and throughou	athroom had ut the inside.					
	Interview on 2/3/22 -Had cleaned the he-Clients help clean client #3 had heme accidents like this co-Had not checked the	ouse everyday. the home as we orrhoids and of on the toilet.	ell. ten had					
	Interview on 2/3/22 -The home had bee few days ago.							

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3J5F11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING.	·		R			
MHL092-791		B. WING	B. WING		02/07/2022				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
ALPHA HOME CARE SERVICES, INC III  3716 ARROWWOOD DRIVE RALEIGH, NC 27604									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
V 736	Continued From pa	ige 3	V 736						
	-Not sure why it wo -Staff should be che mornings to ensure	ecking the bathroom in the							
		been cited five times since 10/4/18 and must be correc							

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