6					PRINTED: 02/09/2 FORM APPRO\	
Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL092-791		B. WING		R 02/07/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3716 ARF	ROWWOOD	DRIVE		
ALPHA H	IOME CARE SERVICI	ES, INC III RALEIGH	, NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 COMPLE	ETE
V 000	INITIAL COMMENT	ГS	V 000			
	completed on 2/7/2 NC 00185552) were deficiencies were c	nt and follow up survey was 2. Intake #'s (NC 00184864, e substantiated and ited. sed for the following service				
	category: 10A NCA Living for Adults wit	C 27G .5600A Supervised the Mental Illness.				
	The survey sample clients.	consisted of three current				
V 118	27G .0209 (C) Med	lication Requirements	V 118	Correct medication and labelin	-	022
	<ul> <li>only be administered order of a person a drugs.</li> <li>(2) Medications shat clients only when a client's physician.</li> <li>(3) Medications, ind administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication recorded immediate MAR is to include the (A) client's name;</li> <li>(B) name, strength (C) instructions for (D) date and time the (E) name or initials</li> </ul>	inistration: non-prescription drugs shall ed 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 a trained by a registered nurse, r legally qualified person and re and administer medications. dministration Record (MAR) of red to each client must be kept is administered shall be ely after administration. The		in the home. QP will monitor and review me and MAR every 30 days to ens medication and MAR are corre	sure ect.	
Division of He	ealth Service Regulation	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE Lato	ya M. Brown TITLE QP	(X6) DATE	 2/16/22

STATE FORM

6899

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Division	of Hoalth Somioo De	aulation			FORM	APPROVED
Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:           MHL092-791					(X3) DATE SURVEY COMPLETED	
		B. WING			R 02/07/2022	
					02/1	5112022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ALPHA H	OME CARE SERVICI	IS INC III	, NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be rec file followed up by a with a physician.	for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	Based on record re failed to ensure one medications were a order of a physician Review on 2/3/22 o -Admission date of -Diagnoses of Bord Attention Deficit wit	view and interview the facility e of three (#2) audited clients idministered on the written n. The findings are: f client #2's record revealed				
	dated 11/2/21 revea	f client #2's physician order aled: 0 mg-one spray in each nostril				
		f Medication Administration aled staff #6's initials beside as administered.				÷
	Review on 2/3/22 or revealed no Flutica	f client #2's medications sone Pro present.				
Division	Pro that morning.	staff #6 stated: ed the last of the Fluticasone				
Division of F STATE FOR	lealth Service Regulation M		6899	3J5F11	If continu	ation sheet 2 of 4

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## PRINTED: 02/09/2022 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791		(X2) MULTIPL A, BUILDING:		(X3) DATE SURVEY COMPLETED R 02/07/2022		
		B. WING				
	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	0210	17 fm O dia dia
	IOME CARE SERVICE	3716 ARI	ROWWOOD			
		KALEIGF	I, NC 27604			1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	ge 2	V 118			
	find it.	e it in the trash and could not refill will be delivered.				0.4.0.10
						2/16/22
V 736	27G .0303(c) Facility and Grounds Maintenance 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.		V 736	Toilets and light bulbs re repairs made to improve		
				Floors cleaned to meet	the standard.	
				Staff will complete hourly checks of the bathroom to ensure the area is clean and suitable for use. QP will monitor monthly to ensure documentation and area meets standards.		nd Ily
	failed to ensure the clean and attractive Observation on 2/3 -Floor throughout th -The toilet in client feces on top of sea -Multiple light bulbs missing.	ion and interview the facility home was maintained in a manner. The findings are: /22 at 11:30 AM revealed he home had areas of dirt on it #2 and #3's bathroom had it and throughout the inside. in both client bathrooms	•			
	accidents like this of -Had not checked t Interview on 2/3/22	ouse everyday. the home as well. orrhoids and often had				

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Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
				R				
		MHL092-791	B. WING		02/0	7/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
		3716 ARE	ROWWOOD					
ALPHA H	IOME CARE SERVIC	ES, INC III RALEIGH	, NC 27604					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE		
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE		
				DEFICIENCY)				
V 736	Continued From pa	ige 3	V 736					
	-Not sure why it wo	uld be so dirty.						
	-Staff should be ch	ecking the bathroom in the						
	mornings to ensure	it is kept clean.						
	This deficiency has	been cited five times since						
		10/4/18 and must be corrected	d					
	within 30 days.							
	-							
Division of H	colth Convice Desculation							
Division of Health Service Regulation STATE FORM			6899	3J5F11	If continua	tion sheet 4 of 4		

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