Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:					
		MHL091-115	B. WING		06/2	4/2022		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ALPHA HOME CARE SERVICES, INC 130 WHITE OAK DRIVE HENDERSON, NC 27536								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
V 000	INITIAL COMMEN	rs	V 000					
	on 6/24/22. The column (intake #NC001890) This facility is licens	aplaint survey was completed implaint was unsubstantiated (52). Deficiencies were cited. Seed for the following service C 27G .5600A Supervised in Mental Illness.						
	census of 3. The su	sed for 6 and currently has a urvey sample consisted of clients and 1 former client.						
V 119	27G .0209 (D) Med	lication Requirements	V 119					
	medication shall be guards against dive (2) Non-controlled sof by incineration, f system, or by trans destruction. A record shall be maintained Documentation shamedication name, so date and method, to disposing of medical witnessing destruct (3) Controlled substances Act, Gould Substan	osal: and non-prescription disposed of in a manner that ersion or accidental ingestion. Substances shall be disposed dushing into septic or sewer fer to a local pharmacy for d of the medication disposal by the program. All specify the client's name, strength, quantity, disposal he signature of the person ation, and the person ion. tances shall be disposed of in e North Carolina Controlled S. 90, Article 5, including any						

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL091-115	B. WING		06/2	24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•		
ALPHA HOME CARE SERVICES, INC 130 WHITE OAK DRIVE HENDERSON, NC 27536							
(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 SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 119	drug supply shall no	ge 1 ot be held for more than 30 the date of discharge.	V 119				
	interview the facility audited clients' (#2)	et as evidenced by: ion, record review and refailed to dispose of 1 of 2 medication to guard against ntal ingestion. The findings					
	 Admission date Diagnosis: Sch Type hospitalization s 5/19/22 no physician or 	of client #2's record revealed: e: 5/19/22 izoaffective Disorder, Bipolar at community hospital 4/13/22- der for Haldol Deaconates (mg) (antipsychotic)					
	medication bin reverse Haldol Dec 10	mg, labeled "Inject 1.5 ml the Dr (doctor) office for this,"					
	 hospitalized in hospital 	2 client #2 reported: May 2022 at a community n the community hospital to					

Division of Health Service Regulation

STATE FORM 6899 22M311 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL091-115		B. WING		06/24/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
ALPHA H	IOME CARE SERVICE	ES. INC	E OAK DRIV			
			ON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 119	Continued From pa	ge 2	V 119			
	lived previously facility prior to hospno longer on th	r in a different residential italization				
	- was not dispen administered by the	ot on Haldol Dec sed at the facility, it had to be				
	(QP) reported: - employed since - visited the facili - responsible for reviewing client me - was in the proc started 2 weeks age the facility - unaware of the bin	2 the Qualified Professional 2 1/11/22 with the company 3 2-3 times a week 3 managing the client records, 4 dications, staff trainings 4 ess of training a new QP that 5 that would be responsible for 5 medication being in client #2's 6 continue order from client #2's 6 aldol Dec				
	Administrator report - "[client #2] is not on the MAR" - "we (the facility order because she medication at the orange - "the new FL2 standard she may have other facility." - "the staff cannot they don't give injection."	ot on that medication, it is not) don't need a (discontinue) do (client #2) was on the				

Division of Health Service Regulation

STATE FORM 6899 22M311 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		MHL091-115	B. WING		06/2	24/2022	
	NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC STREET ADDRESS, CITY, STATE, ZIP CODE 130 WHITE OAK DRIVE HENDERSON, NC 27536						
(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 C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 119	- "[the QP from a	a sister facility] took the harmacy" this morning	V 119				

Division of Health Service Regulation

STATE FORM 6899 22M311 If continuation sheet 4 of 4