


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on April 4, 2023. The complaint was substantiated (Intake #NC 00195106). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <ol style="list-style-type: none"> (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,</p>	V 108		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE QP (X6) DATE 4/27/2023
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	--------------	-----------------------------------------------------------------------------------------------------------------	--------------------

V 108	<p>Continued From page 1</p> <p>the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 current staff (#1) and 2 of 3 former staff (FS #3 & #4) received training to meet the MH/DD/SA needs of the clients. The findings are:</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder, Schizophrenia, other specified and Hyperlipidemia <p>A. Review on 3/15/23 of FS #3's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired on 12/19/22 and separated 1/5/23 - No documentation of diabetes training <p>Review on 3/21/23 of an email dated 3/20/23 from the Licensee revealed:</p> <ul style="list-style-type: none"> - "...[FS #3] had 30 days to fully complete his trainings before he was removed from the schedule. He was only at the facility for two weeks." <p>Review on 3/10/23 of a level I incident report</p>	V 108	<p>The Adminstrator will provide training for all staff in the home that meets MH/DD/SA requirments and expectations. Monitoring will take place monthly by QA Review.</p>	4/6/2023
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIAS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 2</p> <p>dated 1/2/23 for client #4 revealed:</p> <ul style="list-style-type: none"> - "...at about 4 pm yesterday, [Client #4] complained of excessive heat where he was perspiring. I (FS #3) called called the QP (Qualified Professional) of injury, advised (client #4) to calm down and take some rest. At about 6:30pm, after taking a dinner, he complained of feeling dizzy and could not leave from the dining table. I called the 911 who came to check and take him to the hospital" <p>Review on 3/30/23 of an Emergency Medical Services (EMS) report dated 1/2/23 revealed</p> <ul style="list-style-type: none"> - "...primary impression - Diabetic Hyperglycemia...blood sugar (BS) 367..." <p>During interview on 3/15/23 the QP reported:</p> <ul style="list-style-type: none"> - FS #3 worked in the facility for two weeks - FS #3 called her about client #4's incident on 1/2/23 - He (FS #3) told her that client #4 was playing basketball - She (QP) told client #4 to "sit down and relax since he was just active from playing basketball" <p>During interview on 3/15/23 FS #3 reported:</p> <ul style="list-style-type: none"> - Worked at the facility from 12/19/22 to 1/5/23 - Did not have training in diabetes - Saw client #4 sweating "profusely" on 1/2/23 - It was the first time he had ever seen client #4 "like that" - Called the QP and she advised client #4 to "get some rest and not do anything strenuous" - Client #4 told him that "he knew himself and it (sweating) wasn't normal" - Client #4 requested emergency services - Called QP again to get "clearance to call 911" - Client #4 did not play basketball that day - Did not recall seeing client treatment plans 	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 3</p> <p>During interviews on 3/15/23 and 4/4/23 the Administrator reported:</p> <ul style="list-style-type: none"> - FS #3 resigned from the company on 1/5/23 - FS #3 was not in the facility long enough to be trained on diabetes - He was responsible for diabetes training - Staff had 30 days to complete diabetes training <p>During interviews on 3/17/23 and 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - Client #4 was prediabetic when admitted into the facility - Everyone that worked in the facility should be trained in diabetes - Agency used a training software to complete most staff trainings - Trainings not completed through the software were scheduled by administrative staff - The Administrator was responsible for scheduling diabetes trainings <p>B. Review on 3/13/23 of FS #4's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired on 12/20/22 and separated on 3/3/23 - No documentation of diabetes training <p>During interview on 3/21/23 FS #4 reported:</p> <ul style="list-style-type: none"> - Client #4 was a diabetic - Pain was a symptom of diabetes <p>During interview on 4/4/23 the Administrator reported:</p> <ul style="list-style-type: none"> - FS #4 left employment the facility before diabetes training was scheduled <p>C. Review on 3/13/23 of staff #1's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired with the company in 2020 	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 4</p> <p>During interview on 3/13/23 staff #1 reported:</p> <ul style="list-style-type: none"> - Was the first time working in the facility - Worked for the facility as a "fill in" staff since 3/5/23 - Six clients lived in the facility - Was not trained on client treatment plans - Was told to come in and "read the books" - felt she came into the facility "blind" <p>During interview on 3/15/23 and 4/4/23 the QP reported:</p> <ul style="list-style-type: none"> - Was responsible for "individualized client trainings" - She called staff #1 on 3/5/23 to work in the facility - Staff #1 worked in the facility over 6 months ago - She was a "seasoned staff" - "[Staff #1] been in the field for a long time" - She did a brief summary of clients with staff #1 on 3/5/23 - She would usually go over client schedules, FL-2, treatment plans, and facility appointment calendar - "Didn't see the need to go over everything since she's worked in the facility before" <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - The QP was responsible for ensuring staff had training on client demographics, records, and client specific information - The QP should have trained staff on clients' "triggers" so they (staff) would know "what to look out for" <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected in 23 days.</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 5	V 109		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 6</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated the knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 3/13/23 of the QP's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired February 2022 - A job description signed 2/11/22 : - "...QP responsible for coordinating the daily operations of residential, supportive living and/or day habilitation teams - Insure personal growth and independence of services...through initial development and ongoing support, monitoring, supervision, training and hiring of staff - provide opportunities for training to staff as needed. Trainings includes: introduction to DD/SA/MI (Developmental Disability/Substance Abuse/Mental Illness) - assist staff in developing their ongoing job skills and supervise the provision of client's services - assist with transportation of residents to therapeutic appointments when needed" <p>A. The QP failed to ensure staff were trained on the clients' individualized treatment plans:</p> <p>Refer to V108 regarding the details of staff being trained:</p> <p>During interview on 3/15/23 and 4/4/23 the QP reported:</p>	V 109	<p>QP will ensure all staff are trained on all client PCP's, and documentation. Monitoring will take place at least once a month to ensure accurate documentaion. The Administrator will monitor QP at least once a month to ensure training is completed.</p>	4/12/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 7</p> <ul style="list-style-type: none"> - Was responsible for "individualized client trainings" - She did a brief summary of clients with staff #1 on 3/5/23 - "Didn't see the need to go over everything since she's worked in the facility before" <p>B. The following is an example of how the QP failed to follow through with her on-call job duties:</p> <p>Refer to V110 regarding the details of the medical emergency for client #4:</p> <p>Review on 3/31/23 of Emergency Medical Services (EMS) Runsheet dated 3/16/23 for client #4 revealed:</p> <ul style="list-style-type: none"> - "...reports headache since approximately 2200 (11:00 pm)...the pain is primarily on L (left) side of face behind L eye. Pt (patient) also reports blurred vision... Pt became concerned when he checked his BP (blood pressure) at home and found it to be elevated..." - BP ranged from 161/99 to 181/141 <p>Review on 3/20/23 of a hospital medical record dated 3/16/23 for client #4 revealed:</p> <ul style="list-style-type: none"> - "Code stroke" called at 12:15am <p>During interview on 3/24/23 and 4/4/23 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - Staff #1 told her that client #4 had complained of a headache and nausea on 3/16/23 - Was the on call staff on 3/16/23 and she missed the call from staff #1 - "I'm human... I was sleep" <p>C. The following is an example of how the QP failed to coordinate services:</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	<p>Continued From page 8</p> <p>Refer to V291 regarding details of missed follow up appointments for client #4:</p> <p>Review on 3/10/23 of a hospital discharge summary for client #4 dated 9/18/22 revealed:</p> <ul style="list-style-type: none"> - Client #4 reported feeling lethargic, weakness, feverish, and sweating that started 9/17/22 - After care instructions included continue diabetic medication regimen and follow-up with private doctor - "During your ED (emergency department) visit today one of your blood pressure readings was high...follow up with your regular doctor..within the next 4 weeks for reevaluation..." <p>During interview on 3/15/23 and 4/4/23 the QP reported:</p> <ul style="list-style-type: none"> - She was responsible for reviewing and maintaining client records - Could not recall if she saw a September 18, 2022 discharge summary in client #4's record - Could not recall if client #4 followed up on the appointments <p>D. The following is an example of how the QP failed to ensure a client was on a diabetic diet & documentation of his intake foods:</p> <p>Refer to V291 regarding the details of client #4's missed food diary log & diabetic diet:</p> <p>Review on 3/24/23 of client #4's medical record from the primary physician's notes dated 1/24/23 revealed:</p> <ul style="list-style-type: none"> - ".....discussed a diabetic diet and choosing lower carbohydrate foods, more vegetables, less sweets, low/no calorie drinks...Patient (client #4) will complete a food diary...return in 2 weeks with blood sugar log and food diary." 	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 9 During interview on 3/15/23 and 4/4/23 the QP reported: - Was not aware of a food diary or special diet for client #4 This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected in 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 10</p> <p>for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 current staff (#1) and 1 of 3 former staff (FS #4) demonstrated competency required by the population served. The findings are:</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder (ADHD), Schizophrenia, other specified and Hyperlipidemia <p>Review on 3/10/23 of client #5's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 9/7/13 - Diagnoses of Mood Disorder, Mild Intellectual Developmental Disability (IDD), Bipolar Disorder, Obesity, and Borderline IDD <p>A. Review on 3/13/23 of staff #1's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired in 2020 - Started working at the facility on 3/5/23 - Cardiopulmonary resuscitation (CPR) and First Aid training dated 6/8/22 <p>Review on 3/24/23 of a dispatch 911 recording on 3/16/23 revealed:</p> <ul style="list-style-type: none"> - "(Automated System) 22 hours (11:00 pm) 	V 110	<p>The Administrator will provide training for all staff in the home that meets MH/DD/SA requirements and expectations. QP will train staff on how to deal with emergencies and incident reporting monthly. Monitoring will take place monthly by Administrator.</p>	4/6/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 11</p> <p>22 minutes 52 seconds</p> <ul style="list-style-type: none"> - (Dispatch) 911 what's the location of your emergency? - (Client #5) 3716 Arrowwood Drive - (Dispatch) Could you repeat that address for verification? - (Client #5) 3716 Arrowwood Drive - (Dispatch) Okay, is that a house or an apartment? - (Client #5) House - (Dispatch) Okay, tell me exactly what happened. - (Client #5) The patient is a, his um, his blood pressure is 165/118. - (Client #4) "Tell them I got pain on the left side of my head - (Client #5) He's got pain on the left side of his head. - (Dispatch) Okay. And what is your name? - (Client #5) My name is [Client #5] - (Dispatch) [Client # 5] what's your last name? - (Client #5) [Client #5's Last name]... - (Dispatch) Okay, and what's the phone number for you with area code? - (Client #5) Uh...[telephone number] - (Dispatch) Okay, just to verify I'm sending help to 3-7-1-6 Arrowwood Drive, correct? - (Client #5) That's correct. - (Dispatch) Okay, are you with him now? - (Client #5) Yes, I am - (Dispatch) How old is he? - (Client #5) He's 19 - (Dispatch) You said 19? - (Client #5) Yup - (Dispatch) Okay, is he awake? - (Client #5) Yes, he is - (Dispatch) Is he breathing? - (Client #5) Yes - (Dispatch) Is he responding normally? - (Client #5) Yes, he is. You okay [client #4]? 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 12</p> <ul style="list-style-type: none"> - (Client #4)*inaudible* - (Client #5) Aight. - (Dispatch) Is he breathing normally? - (Client #5) Yes - (Dispatch) Is he able to talk normally? - (Client #5) Yes - (Dispatch) And was there a sudden onset of severe pain? - (Client #5) Is it, was it sudden? - (Client #4) huh? - (Client #5) Was it, was the pain sudden? On the left side, was it sudden? - (Client #4) yeah - (Client #5) Yes - (Dispatch) Okay, does he have any numbness or paralysis? - (Client #5) Any numbness or paralysis? - (Client #4) *inaudible* my eye - (Client #5) Just in his eye, he's got pain - (Dispatch) You said he have eye pain? - (Client #5) Yeah, pain in the eye, yeah - (Dispatch) Okay. Has he had a recent change in behavior? - (Client #4) *inaudible* - (Client #5) What's that? - (Dispatch) Has he had a recent change in behavior? - (Client #5) No - (Dispatch) Okay. And exactly what time did these symptoms start? - (Client #5) About 5 minutes ago. Hold on hold on a second. How long did it start [client #4], bout 10 minutes ago? Yeah about 10 minutes ago. - (Dispatch) Okay. Okay we need to do a quick test on him before the medics get there. I want you to get close enough to ask him to do three things. Tell me when you're ready - (Client #5) I'm ready - (Dispatch) Okay ask him to smile 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 13</p> <ul style="list-style-type: none"> - (Client #5) Hey [client #4] smile. Smile. Aight he's got his head down right now, but he's smiling - (Dispatch) Okay. Was the smile equal on both sides of his mouth? - (Client #5) Yes - (Dispatch) Okay. Ask him to raise both arms straight out in front of him and hold for a moment - (Client #5) Hold both arms out straight, hold em, hold em out for a moment. Aight he did. - (Dispatch) Okay. Was he able to raise and hold both arms equally? - (Client #5) Yes. - (Dispatch) Okay. Ask him to say the early bird catches the worm - (Client #5) Say the early bird catches the worm - (Client #4) Early bird catches the worm. - (Client #5) He said it - (Dispatch) Okay, Okay. Alright I'm sending the paramedics to help you now, you stay on the line and I'll tell you exactly what to do next okay. - (Client #5) Okay - (Dispatch) Reassure him help is on the way and from now on don't let him have anything to eat or drink. It may make him sick or cause further problems. Just let him rest in the most comfortable position and wait for help to arrive, okay? - (Client #5) Okie-dokie - (Dispatch) Alright I want you to watch him very closely. If he becomes less awake and vomits quickly lay him on his side. Before the responders arrive put away any pets, gather his medications, unlock the door, turn on the outside lights. Okay? - (Client #5) Okay, I got you - (Dispatch) Alright, if he gets worse in any way call us back immediately for further instructions, okay? - (Client #5) Okay 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 14</p> <ul style="list-style-type: none"> - (Dispatch) Alright, I'm going to let you go now we have help on the way - (Client #5) K, thank you - (Dispatch) You're welcome - (Client #5) Bye Bye - (Automatic System) March 16, 2023 22 hours (11:00 pm) 28 minutes 9 seconds" <p>Review on 3/31/23 of Emergency Medical Services (EMS) Runsheet dated 3/16/23 for client #4 revealed:</p> <ul style="list-style-type: none"> - "...pt (patient) sitting upright in a chair at kitchen table c/o (complained of) headache...reports headache since approximately 2200 (11:00 pm)...the pain is primarily on L (left) side of face behind L eye. Pt also reports blurred vision...advises that he has hx (history) of HTN (hypertension) in his family but has never been diagnosed. Pt became concerned when he checked his BP (blood pressure) at home and found it to be elevated..." - BP ranged from 161/99 to 181/141 <p>Review on 3/20/23 of a hospital medical record dated 3/16/23 for client #4 revealed:</p> <ul style="list-style-type: none"> - "PT (client #4) from home to us from EMS. Sudden onset headache on left side of head behind eye started at 2200 (11:00pm)... Some blurred vision and some dizziness..." - "Code stroke" called at 12:15am - BP ranged from 148/93 to 145/82 <p>During interviews on 3/20/23 and 3/24/23 client #4 reported:</p> <ul style="list-style-type: none"> - Went to the hospital 3/16/23 for sharp pain on one side of his head - Staff #1 was in her room asleep the night of 3/16/23 - Staff #1 came out of her room when he (client #4) knocked on her door 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 15</p> <ul style="list-style-type: none"> - He told staff #1 about the pain in his head - Staff #1 started asking him questions but he "went to sleep on her" - Staff #1 told client #5 to call 911 - Client #5 called 911 - Staff #1 did not know what to do - "She (staff #1) was scared" - "She (staff #1) didn't know all my information. They (clients) know my information except my social" - He (client #5) answered all the questions asked by 911 - EMS took him to the hospital - Hospital used term "code blue" - Was in the hospital overnight for high blood pressure <p>During interview on 4/4/23 client #5 reported:</p> <ul style="list-style-type: none"> - Client #4 asked client #3 to get him (client #5) from his bedroom on 3/16/23 - He was lying in bed almost asleep - Staff #1 was sitting at the dining room table with client #4 - Client #4 was checking his BP - BP was 160/132 - Staff #1 asked him to call 911 - He called 911 - upon EMS arrival, staff #1 gave medics client #4's medications - Staff #1 was "kinda" scared - Client #4 kept falling asleep - "I was scared for [client #4]" <p>Attempted interview with staff #1 on 4/4/23. Staff #1 did not return phone call prior to survey exit.</p> <p>During interview on 3/24/23 and 4/4/23 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - She was told that client #4 had complained of a headache and nausea on 3/16/23 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 16</p> <ul style="list-style-type: none"> - Staff #1 said she checked client #4's BP and called 911 - Was the on call staff on 3/16/23 and she missed the call from staff #1 - "I'm human... I was sleep" - Called staff #1 back as soon as she saw the message the morning of 3/17/23 at around 8:00am - Was not aware client #5 called 911 - "I'm concerned about a lot. That staff did not call 911" - "I'm conerned clients felt more comfortable with another client making the call" - "Another client should not be involved in the emergencies" - "I'm concerned clients felt more comfortable with other clients than with staff" - Would have completed "more in depth emergency trainings" with staff #1 if she had known client #5 called 911 <p>B. Review on 3/13/23 of FS #4's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired on 12/20/22 and separated 3/3/23 - CPR and First Aid training on 12/17/22 <p>Review on 3/24/23 of client #4's primary physician's note dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "[Client #4]..is here today with complaints of CP (chest pain) for over a week. Was playing basketball Tuesday and sharp pain was felt to the left side of his chest which he has to sit down and rest. He also had the chest pain at night. The chest pain is present when he is performing physical activity and has been there for last 2 days...Per [Client #4] he told the GH (group home) worker he was having chest pains on Tuesday (2/22/23) night @ (at) 1030 but they did not call the ambulance. He said he was short of breath at the time." 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	<p>Continued From page 17</p> <p>Review on 3/24/23 of Emergency Medical Services (EMS) Runsheet for client #4 dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "PT (patient) stated the group home would not call EMS on Monday and brought him to his primary care doctor today. Once at his primary they called 911" <p>Review on 3/24/23 of Emergency Department (ED) medical record for client #4 dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "Multiple Medical complaints (Pt (patient) presents to the Ed via EMS from pcp (primary care physician) with no complaints at this time. Pt had chest pain Monday after playing basketball but went away with rest. Pt denies any chest pain or shortness of breath at this time." - BP was 141/79 <p>During interviews on 3/10/23 and 4/4/23 client #4 reported:</p> <ul style="list-style-type: none"> - FS #4 was the staff working on 2/20/23 - He told FS #4 about having chest pains - Sometimes he became light headed while playing basketball - FS #4 told him to lay down and it (chest pains) would "wear off" - He (FS #4) would check on him every 5 minutes to see if he felt better <p>During interview on 3/21/23 FS #4 reported:</p> <ul style="list-style-type: none"> - Worked in the facility from December 2022 to March 1, 2023 - Did not call 911 to the facility for any reason <p>During interview on 4/4/23 the QP reported:</p> <ul style="list-style-type: none"> - Client #4 did not disclose chest pains to anyone - Client #4 and FS #4 were playing basketball 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 110	Continued From page 18 on 2/20/23 - FS #4 noticed client #4 bent over - He (client #4) did not want to go to the hospital so he did not tell staff - FS #4 called her about client #4 on 2/20/23 - Told FS #4 to call 911 if client #4 felt worse - Client #4 does not always tell the truth - "He does not take his health seriously" This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected in 23 days.	V 110		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire & disaster drills were held at least quarterly and conducted under conditions that simulated fire emergencies. The	V 114	QP will ensure staff conduct all fire and disaster drills in the home as scheduled. Monitoring by QP and Administrator will take place at least once a month to ensure all fire and disaster drills are conducted.	4/6/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 19</p> <p>findings are:</p> <p>Review on 3/13/23 of the facility's fire and disaster drills from January 20, 2023 to February 20, 2023 revealed:</p> <ul style="list-style-type: none"> - Fire and disaster drills were documented monthly and on each shift <p>During interview on 3/24/23 client #1 reported:</p> <ul style="list-style-type: none"> - Fire drills were done - Last tornado drill was a year ago <p>During interview on 3/10/23 client #2 reported:</p> <ul style="list-style-type: none"> - The facility did not practice fire or disaster drills - He would go outside by the street for a fire - Would move away from windows during a tornado <p>During interview on 3/15/23 client #3 reported:</p> <ul style="list-style-type: none"> - had not participated in any fire and disaster drills - He would try to get out of the house "asap" (as soon as possible) during a fire - Would go to basement during a tornado <p>During interview on 3/15/23 client #6 reported:</p> <ul style="list-style-type: none"> - The facility did not practice fire and disaster drills - He would go to the mailbox for a fire - Would move away from windows during a tornado <p>During interview on 3/10/23 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - The Administrator was performing a fire and disaster drill audit - The fire and disaster drill logs were unavailable for review 	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 20</p> <p>During interview on 3/15/23 the QP reported:</p> <ul style="list-style-type: none"> - Staff were considered "live in" staff - They (staff) would work "a stretch" of 2-3 weeks - Staff would be relieved when they "requested time off" - She was responsible for reviewing the drills and administration signed off - Would sometimes conduct drills - Reviewed drills monthly - Wanted to "revamp" fire drill process and form to "better identify what the disaster is" <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - The QP was responsible for overseeing drills - The company had a form they used to ensure drills were being done - The QP was supposed to ask clients if drills were being done 	V 114		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(4) A Medication Administration Record (MAR) of</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 21</p> <p>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:</p> <p>(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.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications on the written order of a physician & failed to keep the MAR current for 1 of 3 audited clients (#4) and 1 of 1 former client (FC #7). The findings are:</p> <p>Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V119). Based on observation, record reviews, and interviews, the facility failed to ensure all prescriptions were disposed of in a manner that guards against diversion or accidental ingestion affecting 1 of 3 audited current clients (#4) and 1 of 1 former client (FC #7).</p> <p>Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V120). Based</p>	V 118	<p>The QP will ensure staff will provide all residents in the home medication as prescribed. QP will audit medication closet and MAR on a monthly basis. Monitoring will take place at least once a month by the QP and Administrator to ensure accurate documentation.</p>	4/6/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 22</p> <p>on observation, record reviews, and interviews, the facility failed to ensure medications were stored separately for each client affecting 1 of 3 audited current clients (#4) and 1 of 1 former client (FC #7).</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - An admission assessment dated 6/20/22 with client #4 diagnosed with prediabetes - FL2 dated 2/16/23 with the following medication orders: <ul style="list-style-type: none"> - Glyburide (Diabetes) 5 mg take 1 tab PO daily in the morning with first meal - Glucose (Diabetes) 4 mg take 1 tab PO as needed (PRN) - Accu-check Fastclix (Diabetes) Use as directed three times daily - Accu-check guide test strips (Diabetes) Use one strip via meter three times daily - No blood sugar (BS) log for the month of January <p>A. Review on 3/23/23 of client #4's primary care physician record dated 7/12/22 revealed:</p> <ul style="list-style-type: none"> - Medical diagnosis of diabetes <p>Review on 3/24/23 of client #4's medical record from the primary physician's dated 1/24/23 revealed:</p> <ul style="list-style-type: none"> - "...start checking BS three times daily, keep log and bring to next visit..." <p>Review on 3/10/23 of client #4's BS log revealed:</p> <ul style="list-style-type: none"> - BS was only documented 6 out of 84 opportunities in February 2023 with results ranging from 149-272 - BS was only documented 2 out of 29 opportunities from March 1, 2023 to March 10, 2023 with results ranging from 176-271 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 23</p> <p>Review on 3/10/23 and 3/24/23 of client #4's glucometer revealed:</p> <ul style="list-style-type: none"> - Client #4's BS was checked once a day on 2/3/23, 2/5/23, 2/7/23, 2/8/23, 2/9/23, 2/13/23, 2/14/23, 2/17/23, 2/21/23, 3/6/23, 3/8/23, 3/17/23, 3/18/23, 3/20/23, 3/21/23, 3/22/23, 3/23/23, 3/24/23 with results ranging from 138-282 <p>Review on 3/24/23 of client #4's MAR revealed:</p> <ul style="list-style-type: none"> - No documented BS on January 2023 and February 2023 MARs - BS was documented 7 times in March 2023 with results ranging from 142-221 - Checks were completed once a day except for 2 checks on 3/23/23 <p>During interview on 3/15/23 client #4 reported:</p> <ul style="list-style-type: none"> - He started checking his BS this year - Checked his BS twice a day; "morning and night" - Staff #1 monitored him while he checked his BS - Had an order to check his BS three times a day but it was changed to twice a day - He could not recall when the order was changed <p>During interview on 3/10/23 staff #1 reported:</p> <ul style="list-style-type: none"> - Started working in the facility on 3/5/23 - Client #4 was a diabetic - Client #4 checked his own BS - Checked it once a week - She monitored him and documented the results <p>During interview on 3/13/23 the Qualified Professional (QP) reported:</p> <ul style="list-style-type: none"> - Client #4 was diagnosed with Type 2 diabetes in February of 2023 - Client #4 checked & documented his BS in 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 24</p> <p>February 2023</p> <ul style="list-style-type: none"> - Had a physician order to check BS three times a day <p>During interview on 3/15/23 and 3/24/23 the QP reported:</p> <ul style="list-style-type: none"> - Client #4 did not have a physician's order to check BS at the time of admission - His diabetes was stable when he was admitted - Noticed client #4 had difficulty managing his diabetes in January 2023 - "Pushed" client #4's primary physician to have BS checked - Received a physician order to check his BS three times a day in February 2023 - Saw "holes" in the consistency of documented BS checks - Staff should ensure BS checks were being completed - Former Staff (FS) #4 would document BS on the back of a piece of paper - She developed a form for staff to document BS - BS for February (2023) were recorded on the form but "it grew legs" and cannot be found - Client #4 checked his BS before breakfast and dinner in the facility due to him being at the day program during lunch hours - Planned to discuss with management the best way for client #4 to check his BS while at the day program - Physician changed BS checks to twice a day on 3/20/23 - She was still waiting on the physician order reflecting change <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - Client #4 was prediabetic when admitted to 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 25</p> <p>the facility</p> <ul style="list-style-type: none"> - QP requested for client #4's BS to be checked this year (2023) - Client #4 was on Metformin - Client #4's physician wanted to review any patterns with his BS to see if his medications needed to be increased <p>B. Observation on 3/10/23 at 2:06pm of client #4's medication bin revealed:</p> <ul style="list-style-type: none"> - A small food storage container with client #4's name handwritten on a piece of tape on the container's lid - Inside the small container were the following 4 pills: <ul style="list-style-type: none"> - Big oblong white pill with imprint code G12 similar to medication package dated 12/16/22 of Metformin located in client #4's medication bin - Small pink with imprint code PR034 similar to the medication package dated 2/16/23 of Aspirin located in client #4's medication bin - Small light blue with imprint code C11 similar to the medication package dated 10/10/22 of Ibuprofen located in client #4's medication bin - Small oblong with imprint code 4H2 similar to the medication package dated 1/25/23 of Cetirizine located in client #4's medication bin <p>During interview on 3/10/23 staff #1 reported:</p> <ul style="list-style-type: none"> - Was responsible for making sure clients received their medications - The pills inside the small container were client #4's morning medication dose - She put the 4 pills in the small container this morning (3/10/23) - She punched out each clients medications into a container & placed it back in their medication bins - Client #4 ran out of the house this morning without taking his medication 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 26</p> <ul style="list-style-type: none"> - She yelled for client #4 to come back to take his medication but he did not return - She did not know what to do with the medication, so she put it back in client #4's medication bin - "Haven't crossed that bridge yet" regarding what she was going to do with the medication - She planned to ask the QP what she should have done with client #4's missed medications <p>Observation on 3/10/23 at 3:22pm revealed:</p> <ul style="list-style-type: none"> - Staff #1 asked the QP what to do with the medications. The QP told her that they would discuss it later. <p>During interviews on 3/10/23 and 3/15/23 the QP reported:</p> <ul style="list-style-type: none"> - "The proper protocol should have been her (staff #1) giving the medication by stopping the staff (transportation staff)" - "If he refused then an 'R' should have been documented" (on MAR) - "She should have called the QP and then the doctor would have been called" - She instructed staff #1 to place an "R" on MAR for refusal - She contacted the pharmacy and informed them of the situation - Client #4 did not have an adverse reaction from missed medication - She planned to document the medication error in her "QP Note" for March (2023) - Medications should not be pre-poured prior to administering to clients <p>During interview on 4/4/23 the Licensee reported:</p> <ul style="list-style-type: none"> - Did not see staff pre-pour medications - Staff followed the medication administration trainings 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 27</p> <p>C. Observation on 3/10/23 at 2:06pm of client #4's medication bin revealed:</p> <ul style="list-style-type: none"> - A prescription bottle of Cyclobenzaprine <p>Review on 3/10/23 of client #4's MARs revealed:</p> <ul style="list-style-type: none"> - Cyclobenzaprine was not listed on MARs from October 10, 2022 to March 10, 2023 <p>During interview on 3/20/23 client #4 reported:</p> <ul style="list-style-type: none"> - He hurt his back when he picked something up - Didn't remember when it happened - Took the medicine only one time - He no longer needed the medicine <p>During interview on 3/20/23 the QP reported:</p> <ul style="list-style-type: none"> - The pharmacy did not receive the physician order for the Cyclobenzaprine to be added to the MAR - She was responsible for ensuring the pharmacy received physician orders - Was responsible for the MARs being kept current - The Cyclobenzaprine was added to March 2023 MAR <p>During interview on 4/4/23 the Licensee reported:</p> <ul style="list-style-type: none"> - The QP was responsible for ensuring medications were listed on the MAR <p>Review on 4/4/23 of the Plan of Protection (POP) written by the Administrator on 4/4/23 revealed: "What immediate action will the facility take to ensure the safety of the consumer in your care? Immediate Action 4/4/23 V118-Administration will ensure that staff will document the administration of all client medication as prescribed by the physician order in the chart to prevent risk of medication neglect or error. Monitoring will take place with the coordination of the QP and</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 28</p> <p>Administrator weekly for at least 4 weeks to sure documentation is accurate and current. V 119- Administration will ensure staff will be trained to properly disposal of unused medication in all client medication boxes to prevent the risk of medication error. Monitoring will take place with the coordination of the QP and the Administrator weekly for at least 4 weeks to ensure unused medication are proper disposed. V120- Administration will ensure that staff will be trained to proper storage all client medication to prevent the risk of medication error and client health in the home. Monitoring will take place with the coordination of the QP and Administrator weekly for 4 weeks to ensure medication is storage proper in the client medication containers. Describe your plans to make sure the above happens. Administrator will monitor, document and visit the home to ensure that the above medication concerns are in compliance with the state regulations and policies weekly."</p> <p>This deficiency constitutes a re-cited deficiency.</p> <p>Client #4 & FC #7 were admitted to the facility with diagnoses which included Type 2 Diabetes Mellitus & Schizoaffective Disorder. Since 1/24/23, Client #4 was supposed to have his BS checked three times a day. However, BS were checked 18 out of 155 times between the dates of 1/24/23 and 3/24/23. Staff failed to administer client #4's medication on 3/10/23, which included Metformin that is used to treat diabetes. Staff #1 prepoured client #4's medications in a cup and placed it back in his medication bin after she failed to administer them to him. Client #4 was prescribed Cyclobenzaprine but it was not listed on his MAR from October 10, 2022 to March 10, 2023. FC#7's Caplyta was banded together with client #4's medication in client #4's medication</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 29 bin. FC#7 was discharged in October 2022 & his medications had not been disposed of. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
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. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 30</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure all prescriptions were disposed of in a manner that guards against diversion or accidental ingestion affecting 1 of 3 audited current clients (#4) and 1 of 1 former client (FC #7). The findings are:</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder (ADHD), Schizophrenia, other specified and Hyperlipidemia - Physician orders dated 10/10/22 for the following medications: <ul style="list-style-type: none"> - Cyclobenzaprine (muscle spasm) 10 milligrams (mg) take 1 tablet (tab) by mouth (PO) three times a day as needed (PRN) - Ibuprofen (pain) 600 mg take 1 tab PO every 6 hours PRN - A FL2 dated 2/16/23 for the following medications: <ul style="list-style-type: none"> - Cetirizine (allergy relief) 10 mg take 1 tab PO daily - Aspirin (anti-inflammatory) 81 mg take 1 tab by mouth every morning - Metformin (diabetes) 1,000 mg take 1 tab PO twice a day (BID) <p>Review on 3/20/23 & 3/21/23 of FC #7's record revealed:</p> <ul style="list-style-type: none"> - Admitted 8/6/2022 and discharged 10/1/22 	V 119	<p>QP will ensure all out dated/ unused medication will be properly disposed of in the home within 30 days to the pharmacy to prevent health and safety risk in the home. Monitoring will take place at least once a month by the QP and Administrator to ensure proper disposal of all unused medication.</p>	4/6/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 31</p> <ul style="list-style-type: none"> - Diagnoses of Schizoaffective Disorder (Bipolar Type) and Cannabis Use Disorder - A physician progress note dated 9/1/22: for Caplyta (Bipolar Depression) 21 mg - A FL2 dated 9/13/22: Caplyta 42 mg nightly <p>A. Observation on 3/10/23 at 2:06pm of client #4's medication bin revealed:</p> <ul style="list-style-type: none"> - FC #7's Caplyta 21 mg - FC #7's Caplyta 42 mg - Caplyta 21 mg was rubber banded with client #4's Cyclobenzaprine - Caplyta 42 mg was rubber banded with client #4's Ibuprofen <p>During interview on 3/13/23 staff #1 reported:</p> <ul style="list-style-type: none"> - Worked in the facility since 3/5/23 - Worked as a fill in staff - She noticed the Caplyta but did not know who it belonged to - She rubber banded the medications together to ask the Qualified Professional (QP) about it - She did not administer FC #7's Caplyta to client #4 despite it being in client #4's medication bin <p>During interview on 3/13/23 and 3/15/23 the QP reported:</p> <ul style="list-style-type: none"> - She was responsible for ensuring medications were disposed of - She missed the disposal of FC#7's medication - "It was an oversight" - She did not know how FC #7's medication got into client #4's bin - Visited the home a week prior to survey - She checked the medication closet and bins - The medications were sent back to the pharmacy on 3/12/23 	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 32</p> <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - She visited the facility monthly - Last visit to the facility was the end of February (2023) - She reviewed the clients' medication bins and medications - She did not see FC#7's medication in FC#4's bin <p>B. Observation on 3/10/23 at 2:06pm of client #4's medication bin revealed:</p> <ul style="list-style-type: none"> - A small food storage container with client #4's name handwritten on a piece of tape on the container's lid - Inside the small container were the following 4 pills: <ul style="list-style-type: none"> - Big oblong white pill with imprint code G12 similar to medication package dated 12/16/22 of Metformin located in client #4's medication bin - Small pink with imprint code PR034 similar to the medication package dated 2/16/23 of Aspirin located in client #4's medication bin - Small light blue with imprint code C11 similar to the medication package dated 10/10/22 of Ibuprofen located in client #4's medication bin - Small oblong with imprint code 4H2 similar to the medication package dated 1/25/23 of Cetirizine located in client #4's medication bin <p>During interview on 3/10/23 staff #1 reported:</p> <ul style="list-style-type: none"> - She put the 4 pills in the small container this morning (3/10/23) - Client #4 ran out of the house this morning without taking his medication - She yelled for client #4 to come back to take his medication but did not return - She did not know what to do with the medication in the cup - Planned to call the QP to ask her what to do 	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 33 with the medication During interviews on 3/15/23 the QP reported: - She witnessed staff #1 flush medication down the commode to discard (3/11/23) This deficiency is crossed into 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) for a Type A1 rule violation and must be corrected in 23 days.	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	<p>Continued From page 34</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure medications were stored separately for each client affecting 1 of 3 audited current clients (#4) and 1 of 1 former client (FC #7). The findings are:</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder (ADHD), Schizophrenia, other specified and Hyperlipidemia - Physician orders dated 10/10/22 for the following medications: <ul style="list-style-type: none"> - Cyclobenzaprine (muscle spasm) 10 milligrams (mg) take 1 tablet (tab) by mouth (PO) three times a day as needed (PRN) - Ibuprofen (pain) 600 mg take 1 tab PO every 6 hours PRN <p>Review on 3/21/23 of FC #7's record revealed:</p> <ul style="list-style-type: none"> - Admitted 8/6/2022 and discharged 10/1/22 - Diagnoses of Schizoaffective Disorder (Bipolar Type) and Cannabis Use Disorder - A physician progress note dated 9/1/22: for Caplyta 21 mg (Bipolar Depression) - A FL2 dated 9/13/22: Caplyta 42 mg nightly <p>Observation on 3/10/23 at 2:06pm of client #4's medication bin revealed:</p> <ul style="list-style-type: none"> - FC #7's Caplyta 21 mg - FC #7's Caplyta 42 mg - Caplyta 21 mg was rubber banded with client #4's Cyclobenzaprine - Caplyta 42 mg was rubber banded with client #4's Ibuprofen <p>During interview on 3/13/23 staff #1 reported:</p>	V 120	QP will ensure staff will properly store medications in the home to prevent health and safety risk. QP will audit medication closet to ensure medications are stored properly to prevent comingling of medications. Monitoring will take place at least once a month by the QP and Administrator to ensure proper storage of all medication.	4/6/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 120	<p>Continued From page 35</p> <ul style="list-style-type: none"> - Worked in the facility since 3/5/23 - Worked as a fill in staff - She noticed the Caplyta but did not know who it belonged to - She rubber banded the medications together to ask the Qualified Professional (QP) about it - She did not administer FC #7's Caplyta to client #4 despite it being located in client #4's medication bin <p>During interview on 3/13/23 and 3/15/23 the QP reported:</p> <ul style="list-style-type: none"> - "It was an oversight" - She did not know how FC #7's medication got into client #4's bin - Visited the home a week prior to survey - She checked the medication closet and bins - The medications were sent back to the pharmacy <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - She visited the facility monthly - Last visit to the facility was the end of February - She reviewed the clients' medication bins and medications and did not see FC #7's medication <p>This deficiency is crossed into 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) for a Type A1 rule violation and must be corrected in 23 days.</p>	V 120		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 36</p> <p>these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 37</p> <p>developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E),(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure residential services were provided in a home environment where the primary purpose of these services is the care and habilitation for 1 of 3 audited clients (#4). The findings are:</p> <p>A. Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on record reviews and interviews, the facility failed to ensure 1 of 2 current staff (#1) and 2 of 3 former staff (FS #3 & #4) received training to meet the MH/DD/SA needs of the clients.</p> <p>B. Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record</p>	V 289	<p>The Administrator will continue to ensure all staff including QP are competent in medication administration by providing training using computerized modules. Administrator will meet weekly with QP to ensure all staff and QP are adequate in medication administration.</p>	4/12/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 38</p> <p>reviews and interviews the facility failed to ensure 1 of 1 Qualified Professional (QP) demonstrated the knowledge, skills and abilities required by the population served.</p> <p>C. Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110). Based on record reviews and interviews, the facility failed to ensure 1 of 3 current staff (#1) and 1 of 3 former staff (FS #4) demonstrated competency required by the population served.</p> <p>D. Cross Reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on record reviews and interviews, the facility failed to coordinate with other agencies to meet the needs of 1 of 3 audited clients (#4).</p> <p>Review on 4/4/23 of the Plan of Protection (POP) written by the Administrator on 4/4/23 revealed: "What immediate action will the facility take to ensure the safety of the consumer in your care? Immediate Action 4/4/23 V108- Administrator will ensure that staff are provided training regarding medication administration to all client in the home to ensure that client will be administered their medication as prescribed. Monitoring will take place weekly by the administrator to ensure that staff are competent to administer medication in the home. V109- Administrator will ensure that the QP is provided training regarding medication administration and assessment of client medical needs in the home to prevent the risk of health and safety of all clients. Monitoring will take place weekly by the administrator to ensure that staff are competent to administer medication in the home. V110- Administrator will provide training to the QP regarding providing adequate and competent supervision to staff in the home to</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	<p>Continued From page 39</p> <p>ensure client health and safety. Monitoring will take place weekly by the administrator to ensure that staff are competent to administer supervision in the home. V291- Administrator will provide training to all staff regarding neglect and supervision to all clients in the home to ensure client health and safety. Monitoring will take place weekly by the administration to ensure staff are providing proper supervision to client needs in the home. Describe your plans to make sure the above happens. Administrator will provide staff training regarding supervision/competence for all clients in the home and document progress weekly for 4 weeks."</p> <p>Client #4 was admitted into the facility with diagnoses which included Type 2 Diabetes Mellitus. Client #4 was seen at the hospital on 9/18/22 with elevated blood pressure (BP) & blood sugar (BS). He was requested to follow up with his primary care within 4 weeks. Between September 2022 - Jan 23, 2023 there was no documentation of a follow up visit. The QP was not aware of the 9/18/22 discharge summary in client #4's record. Client #4 had an emergency event related to his diabetes on 1/2/23 that required medical treatment. He was sweating profusely & dizzy. FS #3 was not trained in Diabetes Mellitus and reached out to the QP. The QP instructed client #4 to get some rest and not do anything strenuous. Later that day client #4 was unable to get up from the dining room table and requested FS#3 to contact emergency services. He was transported to the hospital & diagnosed with Hyperglycemia. Client #4 complained of chest pains for two days beginning on 2/20/23. He requested FS #4 to call 911 but FS #4 instructed him to lay down and rest. Client #4 had a scheduled appointment with his primary care physician on 2/23/23 and was transported to</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 40 a hospital via EMS for chest pains. Client #4 had another medical emergency on 3/16/23 with an elevated BP of 181/141. He had pain on the left side of his head accompanied with a headache. Staff #1 instructed client #5 to call 911 and allowed client #5 to communicate with the 911 operator about client #4's symptoms. Client #4 was taken to the hospital with stroke like symptoms. Client #4 had orders for a special diet and to keep a food diary to bring to future appointments. The QP failed to coordinate and implement both physician orders for client #4. This deficiency constitutes as a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 41</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to ensure 3 of 6 clients (#2, #3, and #4) were capable of being in the community without staff supervision. The findings are:</p>	V 290	<p>Staff will continue to monitor and implement all residents PCP including unsupervised time as written to ensure the safety protection in all areas. Monitoring will take place at least once a month by the QP and the Administrator</p>	4/12/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 42</p> <p>Review on 3/10/23 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admitted 10/26/21 - Diagnoses of Anemia, Undifferentiated Schizophrenia, and mixed Hyperlipidemia - No assessment of unsupervised time <p>Review on 3/15/23 of client #3's record revealed:</p> <ul style="list-style-type: none"> - Admitted 8/12/22 - Diagnoses of Schizophrenia and Depression - No assessment of unsupervised time <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder (ADHD), Schizophrenia, other specified, and Hyperlipidemia - No assessment of being capable of unsupervised time <p>Observation at 3:08pm on 3/15/23 revealed the convenience store was located less than a mile from the facility</p> <p>During interview on 3/15/23 client #3 reported:</p> <ul style="list-style-type: none"> - He wanted unsupervised time - Could go to the convenience store as long as he was with "someone" - He walked with client #4 and #5 to the convenience store - Went to the store 1-2 times a week - He bought cigarettes, honey buns, sodas, or "scratch offs" - The convenience store was an "1/8 of a mile" and about "8-minute walk" <p>During interview on 3/15/23 client #5 reported:</p> <ul style="list-style-type: none"> - Walked to the store with client #3 and #4 - Store was about a mile away 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 43</p> <ul style="list-style-type: none"> - It took about 20 minutes to walk to store and back to the facility <p>During interview on 3/10/23 & 3/15/23 staff #1 reported:</p> <ul style="list-style-type: none"> - She worked in the facility since 3/5/23 - Client #4 and client #5 had unsupervised time in the community - Client #3 walked to the convenience store with client #2, #4, and #5 - She did not know where the convenience store was - Clients told her the store was "not that far" - The clients told her when they left the facility and when they returned - She did not have a sign in/out sheet <p>During interview on 3/15/23 the Qualified Professional reported:</p> <ul style="list-style-type: none"> - Only client #5 had approved unsupervised time in the community - She was not aware clients walked to the convenience store - "Clients should not be walking to the convenience store" - She made accommodations for clients to go wherever they needed to go - Company had a transportation van - She or transporting staff would take clients to the store or outings <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - Was not aware clients without unsupervised time walked to the convenience store - The clients used to walk to the store with a former staff 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291 V 291	Continued From page 44 27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate with other agencies to meet the needs of 1 of 3 audited clients (#4). The	V 291 V 291	QP will ensure all staff will continue to follow up with all residents appointments with other agencies according to training. Monitoring will take place once a month by QP reviewing MAR and Progress Notes. The Administrator will supervise montly.	4/12/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 45</p> <p>findings are:</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted on 6/15/22 - Diagnoses of Diabetes Mellitus Type 2, Bipolar Disorder with psychotic features, Attention Deficit/Hyperactivity Disorder (ADHD), Schizophrenia, other specified and Hyperlipidemia - Assessment dated 6/20/22 listed client #4 being prediabetic upon admission to facility <p>A. The following is an example of how the facility failed to follow-up in regards to client #4's blood sugar (BS):</p> <p>Review on 3/15/23 of Emergency Medical Services (EMS) Runsheet for client #4 dated 9/17/22 at 11:14pm revealed:</p> <ul style="list-style-type: none"> - "[EMS] dispatched for diabetic problem at residence....male was found sitting on the couch complaining of 'feeling sick'...house manager called his (client #4) mother who advised to call 911...he (client #4) does not check his sugar regularly...at time of assessment patient was... lethargic...he complained of chills, fatigues, increased urination and hunger..." - Symptoms of "Metabolic-Hyperglycemia, Generalized Symptoms-Fatigue" - Glucose level of 355 <p>Review on 3/10/23 of client #4's ED (emergency department) discharge instructions dated 9/18/22 revealed:</p> <ul style="list-style-type: none"> - Client #4 reported feeling lethargic, weakness, feverish, and sweating that started 9/17/22 - Diagnoses of drowsiness, mild dehydration, and elevated blood sugar levels - After care instructions included continue 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 46</p> <p>diabetic medication regimen and follow-up with private doctor</p> <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - No follow up with primary care physician for BS until 1/24/23 <p>B. The following is an example of how the facility failed to follow-up in regards to client #4's BP:</p> <p>Review on 3/10/23 of client #4's ED discharge instructions dated 9/18/22 revealed:</p> <ul style="list-style-type: none"> - Blood pressure screening with the following information.. "During your ED visit today one of your blood pressure readings was high...It is important that you follow up with your regular doctor..within the next 4 weeks for reevaluation..." <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - No follow up from primary care physician for BP until 2/23/23 <p>Review on 3/24/23 of client #4's primary physician's note dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "Sent to ER (emergency room) for further evaluation. Coordinated with EMS." <p>Review on 3/24/23 of Emergency Medical Services (EMS) Runsheet for client #4 dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "...pt (patient) stated he is in a group home and on Monday he was playing basketball and began having some chest pains that lasted until Tuesday. PT stated the group home would not call EMS on Monday and brought him to his primary care doctor today. Once as his primary they called 911. Upon our arrival the pt has no complaints...doesn't look to be in any distress or pain." - BP-142-148/93 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 47</p> <p>Review on 3/10/23 of ED discharge instructions for client #4 dated 2/23/23 revealed:</p> <ul style="list-style-type: none"> - "You were seen...for chest pains...Please follow-up with cardiology" <p>Review on 3/24/23 of client #4's cardiology after visit summary dated 3/16/23 at 1:40pm revealed:</p> <ul style="list-style-type: none"> - Reason for visit was chest pain, shortness of breath, dizziness, high cholesterol, Type 2 diabetes, class 2 severe obesity and elevated BP without diagnosis of hypertension <p>Review on 3/24/23 of client #4's ED after visit summary dated 3/16/23 at 11:54pm revealed:</p> <ul style="list-style-type: none"> - Reason for visit was stroke like symptoms - Diagnoses of nonintractable headache, unspecified chronic pattern, and unspecified headache type - BP of 148/93 <p>During review & interview on 3/23/23 with the medical record staff at client #4's primary care reported:</p> <ul style="list-style-type: none"> - No follow up visits for medical assessments prior to 1/23/23 - Provided all medical records that were requested <p>During interview on 3/15/23 and 4/4/23 the QP reported:</p> <ul style="list-style-type: none"> - She was responsible for reviewing and maintaining client records - Could not recall seeing a September 2022 discharge summary from the hospital in client #4's client record <p>C. The following is an example of how the facility failed to implement client #4's special diet and food diary:</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 48</p> <p>Review on 3/24/23 of client #4's medical record from the primary physician's notes dated 1/24/23 revealed:</p> <ul style="list-style-type: none"> - ".....discussed a diabetic diet and choosing lower carbohydrate foods, more vegetables, less sweets, low/no calorie drinks...Patient (client #4) will complete a food diary...return in 2 weeks with blood sugar log and food diary." <p>Review on 3/10/23 of client #4's record revealed:</p> <ul style="list-style-type: none"> - No food diary - No special diet <p>During interview on 4/4/23 client #4 reported:</p> <ul style="list-style-type: none"> - Did not keep a food diary - Was unaware of a food diary - The QP did not take him to his follow-up appointments - Transportation staff took him to his appointments - The staff did not come inside during the appointments <p>During interview on 3/10/23 staff #1 reported:</p> <ul style="list-style-type: none"> - Client #4 did not have a special diabetic diet <p>During interview on 3/15/23 and 4/4/23 the QP reported:</p> <ul style="list-style-type: none"> - She was responsible for reviewing and maintaining client records - Was not aware of a food diary or special diet for client #4 - She did not go with client #4 to his primary care appointments - Transportation staff went with him (client #4) inside his appointments - Had a good rapport with client #4's primary care physicians - Physicians would call her on zoom during 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 49 appointments if anything significant came up - She relied "heavily" on staff to communicate with her - If staff did not put physician notes in the client record then she did not see it This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected in 23 days.	V 291		
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. This Rule is not met as evidenced by: Based on observations and interview, the facility was not maintained in a clean and attractive manner. The findings are: A. Observation on 3/10/23 at 1:05pm during facility tour revealed: - Tub with a thick layer of dirt/scum and balls of hair covering the entire bottom surface in upstairs bathroom - Clothes covering the floor in client #1 and #5's bedrooms B. Observation on 3/10/23 at 5:01pm of outside the facility revealed:	V 736	Maintenance will continue to update/repair all areas including inside and outside designated areas. Monitoring will take place at least once a month by using environmental assessment form. The Administrator will supervise this monthly.	4/18/2023

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 3716 ARROWWOOD DRIVE RALEIGH, NC 27604
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	<p>Continued From page 50</p> <ul style="list-style-type: none"> - The metal window frame of the living room window is broken resulting in the metal separating from the window frame and jutting out approximately three inches from the window <p>C. Observation on 3/15/23 at 2:41pm of client #4's bedroom revealed:</p> <ul style="list-style-type: none"> - Clothes covering the floor throughout the room - A 2-Liter soda bottle half-filled and a 52 ounce orange juice bottle both filled with a brown liquid located on his dresser. <p>During an interview on 3/20/23 client #4 reported:</p> <ul style="list-style-type: none"> - He urinated in bottles - "Because I'm diabetic and I can't make it to the bathroom so I went in my room" - He had access to the staff bathroom downstairs closest to his bedroom <p>D. Observation on 3/15/23 at 2:50pm of outside the facility revealed:</p> <ul style="list-style-type: none"> - Screen on client #2's window was off track and protruding approximately 2 inches from window in top left corner <p>During interview on 3/15/23 the Qualified Professional reported:</p> <ul style="list-style-type: none"> - She was responsible for overseeing the repairs to the facility and had a list of repairs that needed to be completed but she did not have a chance to get the repairs done - She was aware the windows in the facility needed repairs - Client #4's bedroom needed to be painted - Planned to get maintenance to come out on 3/16/23 to make repairs - Client #4 stated the liquid in the bottles was his urine - He was "too lazy" to get up and go to the 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES, INC III	STREET ADDRESS CITY STATE ZIP CODE 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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	<p>Continued From page 51</p> <p>bathroom</p> <ul style="list-style-type: none"> - The downstairs bathroom was available for clients to use - Clients should have cleaned the shower after they finished <p>During interview on 3/20/23 the Licensee reported:</p> <ul style="list-style-type: none"> - She visited the facility monthly - She did walk throughs of the facility - The facility has an "environmental track list" for repairs - The list was given to the "handyman" - The protruding window was already reported to maintenance - Maintenance was waiting to receive parts to fix window - Staff, the QP, and she were responsible for checking clients' rooms - Client #4's behavior of urinating in a bottle was "something new" - They (QP and Licensee) were not aware of the behavior of client #4 urinating in bottles <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736		