Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
	MHL092-749		B. WING			R 12/22/2023		
NAME OF I			DDEGG OITY (TATE ZID OODE	1211	LLILULU		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4517 WATERBURY ROAD							
ALPHA H	IOME CARE SERVICE	ES INC II	I, NC 27604	עאט				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
V 000 INITIAL COMMENTS		V 000						
	on December 22, 2	w up survey was completed 023. Deficiencies were cited.						
	category: 10A NCA Living for Adults wit	C 27G .5600C Supervised h Developmental Disability.						
		sed for 6 and currently has a urvey sample consisted of clients.						
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736					
	EXTERIOR REQUI (c) Each facility and maintained in a safe	803 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive						
		et as evidenced by: on and interview the facility s grounds in a safe manner.						
	1:17pm revealed th - 5 electric space facility - 3 were located the hallway and clie - the space heate not turned on	e heaters were observed in the upstairs in the television room ent #1's bedroom er in client #1's bedroom was						
	staff bedroom and t - maintenance at gas heater	rrived with 1 portable propane						
	buring interview on	12/22/23 client #1 reported:						

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-749			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 12/22/2023	
		B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALPHA I	HOME CARE SERVICI	ES INC II	ERBURY RO , NC 27604	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 736	6 Continued From page 1		V 736			
		out yesterday pace heater in her bedroom eep last night & then it was				
	reported: - the heat went of the repairman of the heat	12/22/23 the House Manager out yesterday did not show yesterday to fix pace heaters for heat in the				
	Construction report the facility could heaters or a propar both were fire h other arrangem	d not use multiple space ne gas heater				
	reported: - it was an emergin the facility - staff had to use facility	12/22/23 the Licensee gency situation due to no heat e space heaters to heat the epair the heat system today				
	This deficiency con and must be correct	stitutes a re-cited deficiency sted within 30 days.				
V 774	27G .0304(d)(7) Mi	nimum Furnishings	V 774			
	EQUIPMENT (d) Indoor space re	304 FACILITY DESIGN AND quirements: Facilities licensed 1988 shall satisfy the minimum				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			D	
MHL092-749		B. WING	B. WING		R 12/22/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
ALPHA I	HOME CARE SERVIC	ES INC II	TERBURY RO 1, NC 27604	DAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 774	square footage req time. Unless otherwaresidential facilities 1988 shall meet the requirements: (7) Minimum furnis include a separate table, and storage teach client.	uirements in effect at that wise provided in these Rules, licensed after October 1, e following indoor space hings for client bedrooms shall bed, bedding, pillow, bedside for personal belongings for	V 774				
	Based on observat failed to ensure min bedroom included a and a bedside table Observation on 12/bedroom revealed:	/22/23 at 11:57am of client #5's					
	During interview on reported: - client #5's bedresetup for 2 clients - the other bed was been the bedroom - a mattress and but maintenance has been been been been been been been bee	n 12/22/23 the House Manager room was supposed to be was removed last week ad" and it was removed from I bed frame were purchased ad not set the bed up n 12/22/23 the Licensee the bed had broke yesterday ordered the same day ould be set up in client #5's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COME	(X3) DATE SURVEY COMPLETED	
		MHL092-749	B. WING			R 22/2023
NAME OF I	PROVIDER OR SUPPLIER	•	LDDRESS, CITY, S	TATE, ZIP CODE	12/1	
ALPHA H	HOME CARE SERVICE	- S IN(: II	ATERBURY RO	AD		
		RALEIG	H, NC 27604	DDOV/DEDIC DLAN OF COD	DECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 774	4 Continued From page 3		V 774			
	bedroom					

6899

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