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		
	MHL092-922 B. WING			R 08/22/2024			
NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES #9 STREET ADDRESS, CITY, STATE, ZIP CODE 712 ROCKVILLE ROAD WAKE FOREST, NC 27587							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 000	INITIAL COMMENT An annual and follo on August 22, 2024 This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 3. The suaudits of 2 current of the county emergence of the county em	w up survey was completed. A Deficiency was cited. Sed for the following service C 27G .5600A Supervised h Mental Illness. Sed for 6 and has a current urvey sample consisted of clients and 1 deceased client. COTEMERGENCY PLANS all develop a written fire plan and shall make a copy of legency services agencies upon shall include evacuation utes. Be made available to all staff cedures and routes shall be consisted of clients.	V 000		and ed in aster all y in the ce at wing	10/21/24	
	ealth Service Regulation						

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

TITLE (X6) DATE

RECEIVED BY MHL& C 9/18/24 Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-922		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			R 08/22/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ALPHA I	HOME CARE SERVICI	-S #9	KVILLE ROAI DREST, NC 2			
(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 114	This Rule is not me Based on record refailed to ensure disleast quarterly and findings are: Review on 8/21/24 documented betwee revealed: Two documented 10/2/23 & 1/19/24 Interview on 8/21/2 Participated in Last drill was "a Knew to go out fire and to meet in the Interview on 8/21/2 Participated in Knew to go out hallway during a tor Interview on 8/21/2 Participated in Knew to go out hallway during a tor Interview on 8/21/2 Participated in Knew to go out hallway during a tor Interview on 8/21/2 Participated in Knew to go out hallway during a tor Interview on 8/21/2 Participated in Knew to go out hallway during a tor Interview on 8/21/2 The Qualified Fhim that during a tor Should go under the most center part of Planned to star same way he conducted interview on 8/21/2 Started working 2024	et as evidenced by: view and interview, the facility aster drills were conducted at repeated for each shift. The of the fire and disaster drills een 8/1/23 and 8/21/24 ed disaster drills conducted on 4 client #1 reported: fire and disaster drills a few months ago" side to the mailbox during a the bathroom during a tornado 4 client #2 reported: fire and disaster drills side during fires and in the mado 4 the House Manager drills twice a month ed any disaster drills because to do them Professional (QP) #2 just told mado he and the clients e house or lay down in the the house with no windows t conducting disaster drills the ucted the fire drills	V 114			

Division of Health Service Regulation STATE FORM

FORM 6899 W2LG11 If continuation sheet 2 of 3

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL092-922	B. WING			R 2 2/2024		
NAME OF PROVIDER OR SUPPLIER ALPHA HOME CARE SERVICES #9 STREET ADDRESS, CITY, STATE, ZIP CODE 712 ROCKVILLE ROAD WAKE FOREST, NC 27587								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 114	- The facility was schedule - Believed the Hodisaster drill in June Interview on 8/21/2 Was supposed disaster drill log, bu - The House Mai conduct disaster dr	s given a fire and disaster drill couse Manager conducted a e (2024) 4 QP #2 reported: to check the facility's fire and at didn't check it mager was supposed to ills every month o talk to him right now" about	V 114					

6899

Division of Health Service Regulation STATE FORM

W2LG11 If continuation sheet 3 of 3