

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: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/23/2026
--	---	---	---

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	<p>INITIAL COMMENTS</p> <p>A limited follow up survey for the Type A2 was completed on January 23, 2026. This was a limited follow up survey, only 10A NCAC 27G .0304 Facility Design and Equipment (V752) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .0304 Facility Design and Equipment (V752). No 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 has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____