

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 follow up survey was completed on 5/2/19 Deficiencies were cited.</p> <p>The facility is licensed for the following service category 10A NCAC 27G .5600A Supervised Living for Mentally Ill Adult.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p>	V 112		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>05/02/2019</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET RALEIGH, NC 27604</b>
---	---

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop treatment plans for four of four audited clients (#1, #2, Discharged Client DC #3 &amp; #4) with goals to address their specific needs. The findings are:</p> <p>A. Review on 4/17/19 of client #1's record revealed: -Admission date of 1/11/19. -Diagnoses per FL-2 dated 1/10/19- Sepsis, Chest Pain, Hypertension, Human Immunodeficiency Virus (HIV), Depression, Alcohol Use and Polysubstance Use. -Hospital Admission dated 1/3/19- "Admitted on 1/3/19 for suicidal ideation and sepsis, History of substance abuse..."</p> <p>Treatment Plan dated 2/4/19 revealed the following goals: -Participate in skill building activities...educational and recreational activities... -Alleviate depressed moods and isolation...participate in group activities...develop coping skills... -Abstain from substance use, develop skills...manage behaviors, relapse triggers... -Attends all appointments.</p> <p>Further review on 4/17/19 of Hospital Discharge dated 1/11/19 revealed: -Admitted on 1/3/19 for suicidal ideation and sepsis...History of substance abuse and questionable history of schizophrenia... -Enrolled in [local substance use program], for outpatient substance abuse services.</p> <p>Progress note dated 3/31/19 revealed:</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 112	<p>Continued From page 2</p> <p>-"Transitioning to independent housing on 4/1/19."</p> <p>During interview on 4/17/19 Client #1 stated:</p> <ul style="list-style-type: none"> <li>-Been staying at the facility for 60 days now, transferring to independent living.</li> <li>-Was admitted to the hospital in January 2019 with stomach issues as a result of alcohol abuse.</li> <li>-Been drinking alcohol since age of sixteen.</li> <li>-This was the first time he had been sober this long.</li> <li>-Detoxed while in the hospital prior to admission to the facility.</li> <li>-Activities during the day include going to alcohol antonymous (AA) meetings.</li> <li>-Had a case manager from the hospital that assisted him in placement until they could find him sober living or independent living.</li> <li>-Was told by case manager this was a "transitional placement" until they found him a place to go.</li> </ul> <p>B. Review on 4/17/19 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 1/11/19.</li> <li>-Diagnoses per FL-2 dated 1/21/19 "Alcohol Abuse, Generalized Anxiety and Hypertension.</li> <li>-Hospital admission dated 1/4/19- "suicidal attempt...left and started drinking, attempted to kill himself by taking pills...feeling depressed...ongoing problems with substance use..."</li> <li>--Enrolled in [local substance use program], for outpatient substance abuse services.</li> </ul> <p>Review on 4/17/19 of client #2's Treatment Plan dated 2/21/19 revealed the following goals:</p> <ul style="list-style-type: none"> <li>-Participate in skill building activities...educational and recreational</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 112	<p>Continued From page 3</p> <p>activities... -Alleviate depressed moods and isolation...participate in group activities...develop coping skills... -Abstain from substance use, develop skills...manage behaviors, relapse triggers... -Attends all appointments.</p> <p>During interview on 4/17/19 Client #2 stated: -Had overdosed in January 2019, admitted to hospital and discharged to the facility. -Had overdosed multiple times in the past. -Attends counseling at local substance abuse program. -Attends multiple AA meetings during the week with other housemates. -Case manager with local hospital is helping him move to independent living. -"Not sure why I came here, I guess until they can find me something." -Was told his permanent housing would be available 4/29/19.</p> <p>C. Review on 4/17/19 of Discharged (DC) Client #3 revealed: -Admission date of 3/7/19. -Diagnoses per FL-2 dated 3/7/19 "Alcohol Abuse, Depression, Anxiety, Type 2 Diabetes, Seizure Disorder and Asthma." -Discharge date of 4/3/19. -Hospital discharge dated 3/7/19 "Multiple Hospitalizations...I want to recover from alcohol abuse and control my depression and anxiety."</p> <p>Review on 4/17/19 of Treatment Plan dated 3/11/19 revealed: -Participate in skill building activities...educational and recreational activities... -Alleviate depressed moods and bi-polar</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 112	<p>Continued From page 4</p> <p>symptoms.</p> <ul style="list-style-type: none"> <li>-Abstain from alcohol use, develop skills....</li> <li>-Attends all appointments.</li> </ul> <p>D. Review on 4/17/19 of DC client #4 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 2/27/19.</li> <li>-Diagnosis- Major Depression.</li> <li>-Discharge date of 4/1/19 to "Sober Living House."</li> <li>-Hospital Discharge dated 2/27/19 -"Admitted on 2/16/19 Alcohol Dependence, cocaine use, suicidal thoughts...Alcohol dependence with withdrawal, Alcohol induced mood disorder..."</li> </ul> <p>Review on 4/17/19 of DC client #4's Treatment Plan revealed:</p> <ul style="list-style-type: none"> <li>-Participate in skill building activities...educational and recreational activities...</li> <li>-Alleviate depressed moods and anxiety.</li> <li>-Abstain from substance use...</li> <li>-Attends all appointments.</li> </ul> <p>During interview on 4/17/19 the Licensee stated:</p> <ul style="list-style-type: none"> <li>-Clients are admitted from local hospital.</li> <li>-All clients have "mental health diagnoses."</li> <li>-They do have substance use diagnoses along with "mental health diagnoses."</li> <li>-Develops the treatment plans based on the client needs.</li> <li>-All the clients have the same "mental health" needs.</li> <li>-The clients are admitted and have case managers that help them find permanent placements whether it be sober living or independent living.</li> <li>-The clients do attend AA as part of the community outings.</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 112	Continued From page 5  [This is a re-cited deficiency and must be corrected within 30 days.]	V 112		
V 289	27G .5601 Supervised Living - Scope  10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of 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. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 289	<p>Continued From page 6</p> <p>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 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)&amp;(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 provide services to four of four audited clients (#1, #2, Discharged Client (DC) #3, DC #4) for the purpose of care, habilitation or rehabilitation of individuals who have a primary diagnoses of Mental Illness. The findings are:</p> <p>Review on 4/17/19 of the current License revealed " 5600A Supervised Living for Mentally Ill Adult."</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 289	<p>Continued From page 7</p> <p>A. Review on 4/17/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 1/11/19.</li> <li>-Diagnoses per FL-2 dated 1/10/19- Sepsis, Chest Pain, Hypertension, Human Immunodeficiency Virus (HIV), Depression, Alcohol Use and Polysubstance Use.</li> <li>-Hospital Admission dated 1/3/19- "Admitted on 1/3/19 for suicidal ideation and sepsis, History of substance abuse..."</li> </ul> <p>Treatment Plan dated 2/4/19 revealed the following goal:</p> <ul style="list-style-type: none"> <li>-Abstain from substance use, develop skills...manage behaviors, relapse triggers...</li> </ul> <p>Further review on 4/17/19 of Hospital Discharge dated 1/11/19 revealed:</p> <ul style="list-style-type: none"> <li>-Admitted on 1/3/19 for suicidal ideation and sepsis...History of substance abuse and questionable history of schizophrenia...</li> <li>-Enrolled in [local substance use program], for outpatient substance abuse services.</li> </ul> <p>Progress note dated 3/31/19 revealed:</p> <ul style="list-style-type: none"> <li>-"Transitioning to independent housing on 4/1/19."</li> </ul> <p>During interview on 4/17/19 Client #1 stated:</p> <ul style="list-style-type: none"> <li>-Been staying at the facility for 60 days now, transferring to independent living.</li> <li>-Was admitted to the hospital in January 2019 with stomach issues as a result of alcohol abuse.</li> <li>-Been drinking alcohol since age of sixteen.</li> <li>-This was the first time he had been sober this long.</li> <li>-Detoxed while in the hospital prior to admission to the facility.</li> <li>-Activities during the day include going to</li> </ul>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 289	<p>Continued From page 8</p> <p>alcohol antonymous (AA) meetings. -Had a case manager from the hospital that assisted him in placement until they could find him sober living or independent living. -Was told by case manager this was a "transitional placement" until they found him a place to go.</p> <p>B. Review on 4/17/19 of client #2's record revealed: -Admission date of 1/11/19. -Diagnoses per FL-2 dated 1/21/19 "Alcohol Abuse, Generalized Anxiety and Hypertension. -Hospital admission dated 1/4/19- "suicidal attempt...left and started drinking, attempted to kill himself by taking pills...feeling depressed...ongoing problems with substance use..." --Enrolled in [local substance use program], for outpatient substance abuse services.</p> <p>Review on 4/17/19 of client #2's Treatment Plan dated 2/21/19 revealed the following goal: -Abstain from substance use, develop skills...manage behaviors, relapse triggers...</p> <p>During interview on 4/17/19 Client #2 stated: -Had overdosed in January 2019, admitted to hospital and discharged to the facility. -Had overdosed multiple times in the past. -Attends counseling at local substance abuse program. -Attends multiple AA meetings during the week with other housemates. -Case manager with local hospital is helping him move to independent living. -"Not sure why I came here, I guess until they can find me something." -Was told his permanent housing would be available 4/29/19.</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 289	<p>Continued From page 9</p> <p>C. Review on 4/17/19 of Discharged (DC) Client #3 revealed:            -Admission date of 3/7/19.            -Diagnoses per FL-2 dated 3/7/19 "Alcohol Abuse, Depression, Anxiety, Type 2 Diabetes, Seizure Disorder and Asthma."            -Discharge date of 4/3/19.            -Hospital discharge dated 3/7/19 "Multiple Hospitalizations...I want to recover from alcohol abuse and control my depression and anxiety."</p> <p>Review on 4/17/19 of Treatment Plan dated 3/11/19 revealed the following goal:            -Abstain from alcohol use, develop skills....</p> <p>D. Review on 4/17/19 of DC client #4 revealed:            -Admission date of 2/27/19.            -Diagnosis- Major Depression.            -Discharge date of 4/1/19 to "Sober Living House."            -Hospital Discharge dated 2/27/19 -"Admitted on 2/16/19 Alcohol Dependence, cocaine use, suicidal thoughts...Alcohol dependence with withdrawal, Alcohol induced mood disorder..."</p> <p>Review on 4/17/19 of DC client #4's Treatment Plan revealed:            -Abstain from substance use...</p> <p>During interview on 4/17/19 the Licensee stated:            -Clients are admitted from local hospital.            -This a a "Pilot Program" through local hospital where clients transition to sober living or independent living.            -Client's have the option to stay long term if they choose.            -The clients are admitted and have case managers that help them find permanent placements whether it be sober living or</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-960</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABSOLUTE CARE HUMAN SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3905 IVERSON STREET</b> <b>RALEIGH, NC 27604</b>
---	---

(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 289	<p>Continued From page 10</p> <p>independent living.</p> <ul style="list-style-type: none"> <li>-All clients have "mental health diagnoses."</li> <li>-They do have substance use diagnoses along with "mental health diagnoses."</li> <li>-Develops the treatment plans based on the client needs.</li> <li>-All the clients have the same "mental health" needs.</li> <li>-The clients do attend AA as part of the community outings.</li> </ul> <p>[This is a re-cited deficiency and must be corrected within 30 days.]</p>	V 289		