STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-755	A. BUILDING: _____ B. WING _____	R-C 09/20/2019

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ABSOLUTE HOME AND COMMUNITY SERVICES	5628 MILLRACE RD RALEIGH, NC 27606

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V 000	INITIAL COMMENTS A Complaint and Follow Up Survey was completed 9/20/19. The complaint was unsubstantiated (NC00154333). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
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. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (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 (2) children or adolescents with developmental disabilities shall be served with	V 290		

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V 290	Continued From page 1 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. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (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 (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to monitor periods of unsupervised time for one of three audited clients (#1). The findings are: Review on 9/4/19 of client #1's record revealed: -admitted: 8/17/12 -diagnosis: Paranoid Schizophrenia -assessment dated 1/23/18 indicated approval for 3-4 hours unsupervised time Review on 9/10/19 of discharge paperwork from local hospital dated 9/10/19 revealed the following about client #1 in July 2019 -admitted 7/20/19 at 1:15 PM and discharged 7/24/19 -discharge diagnosis listed principle problem as heat stroke -hospital course: "apparently went for a walk	V 290		

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V 290	Continued From page 2 and never came back. He was found down by bystanders that called 911..." During interview on 9/11/19, staff #1 reported: -clients wrote their name and what they were doing on the calendar when they left the home for unsupervised time -the calendar was a general calendar used by the agency for appointments and not specifically for unsupervised time -on 7/20/19, client #1 wrote he was going for a walk on the calendar. He did not document a location or general area. Most of the time, he usually went down the street to play basketball. During interview on 9/12/19, the Qualified Professional reported: -she was not sure of the specific processess for signing in and out at this group home as she provided oversight at many homes -was not aware of any specific guidelines or systems to identify where clients were going or the estimated length of their unsupervised time for the day	V 290		
V 291	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.	V 291		

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V 291	Continued From page 3 (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 review and interview, the facility failed to coordinate services between the facility operator and the qualified professionals responsible for treatment/habilitation or case management of one of three audited clients (#1). The findings are: Review on 9/4/19 of client #1's record revealed: -admitted: 8/17/12 -diagnosis: Parnoid Schizophrenia -no paperwork of hospitalization in 2019 Review on 9/10/19 of discharge paperwork from local hospital dated 9/10/19 revealed the following about client #1 in July 2019 -admitted 7/20/19 at 1:15 PM and discharged 7/24/19 -discharge diagnosis listed principle problem	V 291		

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V 291	Continued From page 4 as heat stroke -hospital course: "apparently went for a walk and never came back. He was found down by bystanders that called 911 and initially had tympanic temp of 107, combative and altered." He did not recall occurrences of morning walks or even being at the group home that morning. Lab results yielded "postive for Benzo and Cannabinoid and alcohol level 6.6. He denied any drug use and when gently confronted about his urine drug screen being positive for cannabinoids, he has no explaination for this. He also denies any recent alchol intake, despite a (weakly) positive alcohol level" on admission During interview on 9/12/19, the Qualified Professional reported: -upon discharge from the hospital on 7/24/19, client #1 was picked up by his mother -she had requested the 7/24/19 hospital discharge paperwork from client #1's mother. As of 9/12/19, client #1's mother had not provided the group home the hospital discharge information. She was not aware of the official medical diagnosis for the 7/24/19 hospital discharge but thought it was a heat stroke. She was not aware of any follow up needed or concerns addressed on the discharge summary. -client #1 had a previous history (prior to 2016) of substance abuse. She was aware of any recent incidents of concerns regarding substance use for client #1. Prior to this interview, she was not aware of any hospital information that would indicate concerns of substance use.	V 291		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

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V 736	Continued From page 5 (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 observation, interview and record review the facility failed to maintain the home in a safe and attractive manner. The findings are: Review on 9/3/19 of the facility's public file maintained by the Division of Health Service Regulation (DHSR) revealed Statement of Deficiency (SOD) Report dated 6/12/19 from Mental Health Licensure Construction Section of recited violations inclusive of the following regulatory areas: -emergency plans and Supplies (staff not documenting drills were conducted) -facility grounds and maintenance (evidence supported citations in reference to client and staff bedroom areas-dust, kitchen-grease build up over stove/hood/range as well as countertops, living room facility grounds) -safety-(trip hazards in client areas either by cable wires or laminate floors, exposed nails or screws, weak or rotted wood related to structural areas of the property) -maintenance of electrical system-(inadequate lighting throughout the home) Observation and tour of the facility on 9/4/19 between 9:30AM-12:00 Noon of the three level facility revealed the following: (Note an Asterisk * indicates was identified and cited during the 6/17/19 survey) A. Top Level:	V 736		

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V 736	Continued From page 6 -master bedroom occupied by client #1 *closet- wire clothes hanging rack not fully attached to wall..mold noted in door jam *laminate floors not flush together with potential trip hazard *broken molding noted...tub dirty with water stains & dirt.. *vanity sink cabinet (door broken ...inside cabinet evidence of water damage inside and warped) *blinds dirty *dirt and mold noted in shower bathroom closet door frame wood broken dust noted in ceiling near exhaust ceiling plaster peeling, "flaking", or seperating in both bathroom and bedroom areas -single bedroom occupied by client #3 with exit door *laminate flooring not "flush" together *emergency escape-railing unstable even with light touch ...railings separated from deck...nails exposed as not secured to stairway -single bedroom occupied by client #4 *tri-fold closet door missing knob...screw exposed..holes inside *semi-circle marking embedded in flooring consistent with closet door being opened and closed *dust on light fixture window sill dirty and thick cobwebs noted in areas between double paned window During interiew on 9/4/19, staff #1 reported: -the clients cleaned their rooms and she provided oversight. Since June 2019, she felt the	V 736		

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V 736	Continued From page 7 facility had made improvements During interview on 9/4/19, the Qualified Professional reported: -client #4 removed knobs to make necklaces -she was not aware of the holes in client #4's closet During interview on 9/10/19, the DHSR construction section consultant reported: -the deck moved/ shook when the railing was touched. B. Main Level: -living room *thin blue marking on the living room wall *3 Televisions placed beside one another reducing space to access the dinner table (two noted during the 6/17/19 survey) *missing bulbs in light fixture -kitchen/staff area kitchen-Countertops chipped exposing building material, cabinet drawers not able to open ...grease build up underneath range of stove *staff area: sliding glass door covered with a white heavy film which prevented someone from seeing to the outside (not easy to open by staff #1 as demonstrated during 9/3/19 tour) -laundry area *peeling around floor molding -garage *door jam rotting During interview on 9/4/19, the Qualified	V 736		

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V 736	Continued From page 8 Professional reported: -Administrator/Registered Nurse (RN) had spoken with someone about replacing the countertops and cabinets in the kitchen. The landlord did not want to assist with the cost -could not explain why the facility had so many broken televisions. The Administrator/RN's husband had scheduled someone to come to the facility on Thursday 9/5/19 to pick up the televisions as at least one was heavy to move -prior to her arrival the morning of 9/4/19, she thought all the light bulbs had been replaced. She left the facility to go to the store to get a few light bulbs but during the tour with DHSR, realized she needed more bulbs C. Lower Level: -room occupied by client #2 and client #5 *light fixture missing light bulb over both client beds *door jam rotted outside of exit door *threshold broken (need to be replaced) -hallway *tarnished mirror with broken stand in the hallway cable wires running across floor from one side of the wall to the next (trip hazard) -bathroom *missing bulb in vanity stain on ceiling near exhaust vent -exit door located near bathroom *threshold lift up when foot placed on top (can be lifted with foot..not secure door) debris near the hallway before exit door light bulbs missing which leaves no	V 736		

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V 736	Continued From page 9 lighting in the hallway leading to outside During interview on 9/4/19, the Qualified Professional reported: -prior to 9/4/19, she was not aware the threshold near the exit door located near the bathroom was not secure -she thought the items identified on the 6/17/19 had been completed. The Administrator/RN provided oversight of the physical property and maintenance of the group home. D. Facility Grounds: *old broken chairs (some with no frame, others with no cushion) old door underneath the fire escape *deck outside of staff area designated as exit/emergency escape: Soft Wood noted on boarding of the deck. 1/2 of the deck discolored while others had boards that appeared to be newer or pressure washed...last step at bottom of deck broken. During interview between 9/4/19 and 9/9/19, DHSR Construction Surveyor revealed the following: -he was involved in the 6/12/19 survey with his supervisor and a peer -compared to the 6/12/19 survey, the facility had implemented some minor corrections. Some major items previously identified regarding safety such as the railings and escape route, trip hazards which could result in client injury continued to remain non compliant. -in regards to the fire escape off client #3's bedroom, he characterized the steps as unsteady and railing with the slightest of pressure caused the deck to move. (Previously noted in 6/17/19 interview this "deck was an estimated 25 foot	V 736		

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drop ..Should someone fall from that drop, serious injury or death could occur")
-middle board was rotten and someone could fall through it.

During interview on 9/4/19, staff #1 reported she:
-was the same staff who conducted the facility tour with both DHSR construction and mental health licensure section during the June 2019 survey.
-thought the facility had completed the items identified on the SODs from June 2019

During interview on 9/4/19, the Qualfied Professional reported:
-it was her understanding the Administrator/RN came to the facility a few weeks prior to 9/4/19 to assure items were completed.
-prior to 9/4/19, she had not seen the 6/12/19 SOD from construction..she would follow up with the Administrator/RN to see if it was sent to the corporate email. She would consult with Administrator/RN to complete the Plan Of Correction (POC) for construction if needed.
-she and the Administror/RN completed a POC for the 6/17/19 Mental Health Licensure Survey. The 6/17/19 POC was faxed to DHSR. Her agency had some difficulty determining if faxes were sent so she was not able to provide documentation to support the 6/17/19 POC was completed/fax. She would check and fax both POCs to DHSR by the close of business.

Review on 9/3/19 of the facility's public file maintained by the DHSR of SOD Reports from both Mental Health Licensure and Construction Sections between 11/13/15 and 6/17/19 revealed:
-a total of 12 times the facility was cited for facility maintenance concerns.
-identified areas of non compliance inclusive

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V 736	Continued From page 11 of safety of the deck/railing, structural issues with rotting wood, non working condition of the garage, cleanliness of the facility and its grounds Review on 9/9/19 the facility's Plan of Protection dated 9/5/19 and submitted by the Qualified Professional revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from additional (QP) harm? Effective 9/5/19, the maintenance person has started the process of replacing more boards & affixing the unattached posts on the decks. The deck will be completely repaired & restored to meet safety standards within the next 7 days. The debris around the house will be removed within the next 7 days. Current debris (including the couch in the garage) will be removed within 72 hours. All other debris created from the current work being done will be removed by the end of the projection date of completion (7 days). The doors have all been replaced and one door threshold needs to be replaced. The cleaning will be done by a professional cleaner. The staff in that home has been replaced until the house is brought up to standards. The cable company has been contacted to reposition the cable wiring ao as not to create a safety hazard in the downstairs area of the home. The floor boards that are separated will be repaired or replaced so as to remove any safety concerns. The areas of the home in need of painting will be painted within the next 23 days. These repairs will be monitored and overseen by administrator and QP. The QP will conduct inspections at the end of each 7 day period. The administrator should check twice weekly. Describe your plans to make sure the above happens. The Administrator has contracted with 2	V 736		

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V 736	Continued From page 12 contractors who will do monthly inspections of the structure and report findings to the administrator. Any repairs deemed to be safety risk will be corrected immediately. The administrator or designee will do no less than biweekly inspectins of the facility toensure there are no safety risks." This facility housed five male clients with varying diagnoses inclusive of Paranoid Schizophrenia, Bipolar Mood Disorder, Diabetes, Personality Disorder, Antisocial Behavior, Paranoid Delusions, Moderate Mental Retardation, Congestive Heart Failure, Hypertension and Asthma. Ongoing needed repairs in the home not completed since 2015 included but were not limited to loose boards on deck/unsecured railing, gaps noted in the floor and build up of dust. The unsecured railings of both decks designated as fire escape routes for egress routes would impact the safety of the clients during an emergency evacuation for both the top level and the main level of the house. The same issues were noted during this September 2019 Follow Up. This deficiency constitutes a Continued Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	V 736		