

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 COMMENTS An Annual and Follow Up Survey was completed December 6, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108		

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: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 108	<p>Continued From page 1</p> <p>clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure one of three staff (#2) had current training in cardiopulmonary resuscitation (CPR) and First Aid. The finding is:</p> <p>Review on 12/06/19 of the facility's personnel record for staff #2 revealed: -Hired: September 2019 - No CPR and First Aid and First Aid training</p> <p>During an interview on 12/03/19, the Qualified Professional reported: -The Registered Nurse/Administrator maintained the personnel records and prepared the records for this survey -She was not aware staff #2 did not have training in her CPR and First Aid training in her personnel record</p>	V 108		
V 117	<p>27G .0209 (B) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 117	<p>Continued From page 2</p> <p>packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;</p> <p>(3) The packaging label of each prescription drug dispensed must include the following:</p> <p>(A) the client's name;</p> <p>(B) the prescriber's name;</p> <p>(C) the current dispensing date;</p> <p>(D) clear directions for self-administration;</p> <p>(E) the name, strength, quantity, and expiration date of the prescribed drug; and</p> <p>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to assure one of four audited client's (#5) medication was not expired. The finding is:</p> <p>Review on 11/21/19 of client #5's record revealed the following:</p> <ul style="list-style-type: none"> -Admitted: prior to 2017 -Diagnoses: Mental Retardation, Hypertension and Seizure Disorder -November 2019 MAR included Lorazepam .5mg one tablet twice a day as needed (used to treat anxiety disorder) <p>Observation on 11/22/18 between 1-4:00 PM of client #5's medication revealed:</p>	V 117		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 117	<p>Continued From page 3</p> <p>-Lorazepam .5 mg with a dispense date of 10/28/18 and an expiration date of 10/28/19.</p> <p>During interview on 11/22/19, staff #1 confirmed the above medication was expired. She was not aware the Lorazepam had expired.</p> <p>During interview on 12/03/19, the Qualified Professional reported she was not aware the Lorazepam had expired. She would make the Registered Nurse/Administrator aware and to follow up with the pharmacy to develop a better system.</p>	V 117		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 4</p> <p>(D) date and time the drug is administered; and (E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure staff demonstrated competency to administer medications as well as assure the MAR was current affecting four of four audited clients (#1, #3, #5 and #6). The facility failed to assure medication was available to administer as well as have physician's orders for three of four audited clients (#3, #5 and #6). The findings are:</p> <p>Review on 11/21/19 of client #1's record revealed the following: -Admitted: Prior to 2017 -Diagnoses: Intellectual Developmental Disability, Hypertension, Insomnia and Impulsive Control Disorder -November 2019 MAR included: -Risperdal .5 mg (milligram) one tablet (used to treat schizophrenia, bipolar disorder and irritability caused by autism) -Metformin HCL 500 mg one tablet (commonly used to treat Diabetes but has other uses including weight loss) -Lexapro 10 mg one tablet (used to treat depression and generalized anxiety disorder) -Lotrel 5-20mg one tablet (used to treat hypertension)</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Multivitamin one tablet -Singular 10 mg one tablet (used to treat allergies and prevent asthma attacks) <p>Review on 11/21/19 of client #3's record revealed the following:</p> <ul style="list-style-type: none"> -Admitted: prior to 2017 -Diagnoses:Mild Mental Retardation, Schizoaffective and Hyperlipidemia -November 2019 MAR included: <ul style="list-style-type: none"> -ProAir HFA 90 mcg (microgram) 2 puffs as needed (used to treat or prevent bronchospasm) <p>Review on 11/21/19 of client #5's record revealed the following:</p> <ul style="list-style-type: none"> -Admitted: Prior to 2017 -Diagnoses: Mental Retardation, Hypertension and Seizure Disorder -November 2019 MAR included the following: <ul style="list-style-type: none"> -Zoloft 100 mg one tablet (used to treat social anxiety and panic disorders) -Prilosec 20 mg one tablet (used for treatment of Gastroesophageal Reflux Disease) -Norvasc 10 mg one tablet (used to treat hypertension) -Vimpat 100 mg one tablet (used to treat partial seizures) -Depakote 500 mg one tablet and Tegretol-XR 200 mg one tablet (used for treatment of bipolar and seizure disorders) -Phenobarbital 32.4 mg one tablet (used for treatment of epilepsy) -Carnitor 300 mg one tablet (dietary supplement used to treat Carnitine deficiency) -Risperdal .5 mg one tablet (used to treat certain mood/mental disorders) -Irbesartan-HCTZ one tablet (used to treat hypertension) -Albuterol Sulfate .083% Inhale Solution 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 6</p> <p>(Proventil) "inhale contents of one vial in nebulizer every 8 hours as needed for shortness of breath/cough/wheezing" (used to treat or prevent bronchospasm). -Lorazepam .5mg one tablet twice a day as needed (used to treat anxiety disorder) -Epipen .03 % as needed (used to treat severe asthma attacks or allergic reactions)</p> <p>Review on 11/21/19 of client #6's record revealed the following: -Admitted: Prior to 2017 -Diagnoses: Mild Mental Retardation and Schizophrenia -November 2019 MARs included the following: -Combivent one puff four times a day (used to treat chronic obstructive pulmonary Disease) -Proair HFA 2 puffs as needed -Proscar 5 mg take one tablet daily (shrink benign prostate in men) -Zyloprim 300 mg take one tablet daily (used to treat gout or kidney stones) -Lipitor 20 mg take one tablet at bedtime (used to treat high cholesterol) -Prilosec 40 mg take one tablet daily -Tricor 145 mg take one tablet daily (lowers cholesterol)</p> <p>Review on 12/03/19 of staff #1's personnel record revealed the following: -Hired: 01/2018 -Training in Medication administration dated: 01/22/19</p> <p>A. Staff competency for medication administration:</p> <p>Observation on 11/21/19 between 9:00-9:30AM</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 7</p> <p>revealed clients #4, #5 and #6 in the living room area, staff moving between the living room area and the staff quarters. Five plastic containers on the room divider separating the kitchen and the living room areas. Each container had initials on top. Two containers with initials for clients #1 and #5 had medications inside.</p> <p>Review on 11/22/19 of November 2019 MAR for client #1 listed the following pill medications should be administered in the AM:</p> <ul style="list-style-type: none"> -Risperdal -Metformin -Lexapro -Lotrel -Multivitamin -Singular <p>Review on 11/22/19 of November 2019 MAR for client #5 listed the following pill medications should be administered in the AM:</p> <ul style="list-style-type: none"> -Zoloft -Prilosec -Norvasc -Vimpat -Depakote -Tegretol -Phenobarbital -Carnitor -Risperdal -Irbesartan-HCTZ <p>During interviews between 11/21/19 and 11/22/19, staff #1 reported:</p> <ul style="list-style-type: none"> -11/21/19: Client #1's transportation arrived to transport him to his day program. Client #1 left the group home without taking his medication. Client #5 was asleep so his medications remained on the counter. She does not awaken client #5 to take his medication. 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 8</p> <p>-11/22/19: In general, she administered medications by placing one dosage of medication inside the plastic containers on the counter and clients would get their medications. She recalled taking medication administration training with a nurse. Steps provided in the training were to call clients individually, give clients medications, provide clients water, observe clients take medicine as well as drink water, assure clients took medications by opening their mouth and then document on the MAR after medications were consumed or note otherwise.</p> <p>During interview on 12/03/19, the Qualified Professional reported: -Normal procedure for medication administration to be administered to clients is individually by staff. Would have concerns if client picked up the wrong medication</p> <p>B. Medications not in the facility</p> <p>Observation on 11/21/19 of the facility's medications revealed the following were not at the group home: -ProAir for client #3 -Albuterol Sulfate medication or Nebulizer machine for client #5 to administer the Albuterol -Combivent and ProAir for client #6</p> <p>During interview on 11/21/19, staff #1 reported the following: -Client #3 did not use ProAir -Client #5 never had a vial of Albuterol Sulfate or a nebulizer machine -She could not locate client #6's Combivent. She normally kept the Combivent on the dresser located in the staff's bedroom as client #6 used Combivent throughout the day.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 9</p> <p>During interview on 11/25/19, the pharmacist used by the facility reported:</p> <ul style="list-style-type: none"> -In regards to client #3- ProAir physician's orders on file dated 01/07/19 and 11/22/19. Pharmacy dispensed 05/11/19 & 11/22/19 -In regards to client #5- A nebulizer machine would be needed to administer the medication. The pharmacy does not supply nebulizer machines. A machine could be purchased at a medical supply store. -In regards to client #6- Combivent physician's orders dated 07/02/19 was dispensed 11/22/19 and previously dispensed in June 2019. A medication review conducted in June 2019 indicated three extra medication boxes on site which should have lasted until October 2019 . This represented under usage and no medication. The group home called the pharmacy on 11/22/19 and the medication was dispensed. <p>During interview on 12/03/19, the Qualified Professional reported:</p> <ul style="list-style-type: none"> -Medications should be ordered from the pharmacy by staff when 7 days of medications supply remained. -During this survey, she had spoken with the pharmacy regarding missing medication at the group home. The missing medication was dispensed <p>C. No doctor's orders</p> <p>Review on 11/21/19 of the facility's records revealed:</p> <ul style="list-style-type: none"> -Client #3- September-November 2019 MARs: no initials to indicate ProAir was administered. No physician's order for ProAir -Client #5- September-November 2019 MARs: no initials to indicate Lorazepam, Albuterol Sulfate and Epi-pen were administered. No 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 10</p> <p>physician's order for Lorazepam, Epipen and Albuterol Sulfate.</p> <p>-Client #6-No physician's order for ProAir, Proscar, Zylprim, Lipitor, Prilosec and Tricor. September-November 2019 MARs: Initials indicate those medications were administered except ProAir</p> <p>During interview on 11/21/19, staff #1 reported she:</p> <p>- Did not know what happened to the missing physician's orders in the client's records.</p> <p>-Checked all clients' record booklets (Travel, Main and the MAR) for the missing physician's orders.</p> <p>During interview on 11/25/19, the pharmacist used by the facility reported:</p> <p>-In regards to client #5-Nebulizer treatment original physician's order dated 09/20/2018. Over the weekend (11/23/19) another physician's order was written for him. Client #5's Epipen physician's order dated 04/23/19 was on file.</p> <p>During interview on 12/03/19, the Qualified Professional reported:</p> <p>-Some of the client records maintained at the group home had been purged. She felt the current physician's order for some of the medications were at the corporate office. The fax machine at the corporate office had not been operable for months.</p> <p>-Since 11/20/19, she had spoken with a representative at the pharmacy and the (Registered Nurse) RN/Administrator. The Nebulizer treatment and Medication had been mistakenly placed on the FL2 and signed by the physician. The pharmacist used the signed FL-2 form as a current doctor's order</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 11</p> <p>D. MARS not filled in</p> <p>Review on 11/20/19 of clients #1, #3, #5, #6's November 1-20, 2019 MARs revealed all medications and times were blank on the MAR.</p> <p>Review on 11/21/19 of client #1's November 2019 MAR revealed: -Initialed daily between 1-20th -Note: reference example A above in which observation reflects client#1 did not receive AM medication on 11/20/19.</p> <p>During interview on 11/22/19, staff #1 reported: -She forgot to sign the MARs for November. She indicated she had been sick, not feeling well, staff #2 filled in for her. Then she could not recall if staff #2 worked as her relief in October or November 2019. -The Qualified Professional had reminded her within the past few weeks to review everything and have it in order because the house could be surveyed at anytime</p> <p>During interview on 12/03/19, the Qualified Professional reported: -The Administrator was also a RN and she primarily provided oversight for medical concerns (training, review) -The Qualified Professional conducted mocked reviews every 3-4 months of clients records which would include medication overview. The last review was held in October 2019. She was not sure what happened with this group home regarding the identified citations.</p> <p>Review on 12/03/19 the facility's Plan of Protection dated 12/02/19 and submitted by the Qualified Professional revealed: -"What will you immediately do to correct the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	<p>Continued From page 12</p> <p>above rule violations in order to protect clients from further risk or additional harm?</p> <p>Staff received immediate training from the Administrator on the night of 11/27/19. This is the date that the facility was made aware of the concerns observed on 11/20/19. The training included: documentation on MARs, medication storage, proper medication administration procedures-including location and administering to one person at a time in the location locations. Staff will receive more indepth training by a registered nurse on 12/15/19. Any future deviations from proper medication procedures will result in consequences, up to and including termination. Staff will also be trained on ordering medications to ensure a client is never out of prescribed medications. Ensure all meds are current/not expired</p> <p>-Describe your plans to make sure the above happens.</p> <p>The RN/Administrator will review MARs and do observations of the medication administration procedure at least once monthly for up to 6 months or if the RN finds that the staff is able to demonstrate proper techniques and protocols and has zero deviations then the RN can determine that the observation period be completed."</p> <p>Facility staff #1 worked in a live-in capacity until she decided to seek time off an average of once every few months. All clients in this home had diagnoses of Intellectual Developmental Disability and some Mental Illness. Prior to this survey, the facility had developed and implemented a system of program review for medication compliance which included review of records. The facility's internal monitoring system failed to identify issues such as staff leaving client's medication out for self administer, prescribed medications not</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 118	Continued From page 13 available in the facility to be administered, no physician's orders maintained on file by the facility and assure MARs were accurate and current. The lack of medication administration oversight was neglectful that any client could consume a peer's medications without staff's knowledge. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
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. (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	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 291	<p>Continued From page 14</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate services with other qualified professionals responsible for treatment/habilitation of one of three clients (#3). The findings are:</p> <p>Review on 11/22/19 of client #3's records revealed: -Admitted: Prior to 2017 -Diagnoses: Mild Mental Retardation, Schizoaffective and Hyperlipidemia -Physician's order dated 05/13/19 sleep study ordered -No further follow up noted for the sleep study</p> <p>Review on 11/21/19, staff #1 reported about client #3's sleep study: -She took him once for a sleep study -Estimated 4 months ago the sleep study was initiated -He did not fall asleep during the study -The Psychiatrist ordered the sleep study and asked him to go back to take the sleep study again. Client #3 agreed to go back</p> <p>During interview on 11/25/19, the nurse at Psychiatrist office revealed the following: -Referral was made for the sleep study</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 291	<p>Continued From page 15</p> <p>because client #3 had signs of irritability, not sleeping at night, sleeping during the day and excessive snoring.</p> <ul style="list-style-type: none"> -Initially changes were made for all his medications to be given at night. The signs and symptoms still existed so a sleep study was ordered. -No medications changes have been made. The Psychiatrist awaits the outcome of the sleep study to rule out sleep apnea. <p>During interview on 11/25/19, the specialist at the sleep study lab identified by staff #1 revealed:</p> <ul style="list-style-type: none"> -Diagnostic study was done overnight in August 2018 -During that study, he did not fall asleep. A home sleep study was ordered by the sister entity within the company. Per their documentation, they could not locate him to set up the home study. -No other sleep study had been conducted by their agency since August 2018 <p>During interview on 12/03/19, the Qualified Professional reported:</p> <ul style="list-style-type: none"> -In regards to the home sleep study, she never received any follow up from the sleep lab regarding the home sleep study. -She thought client #3 had a sleep study in 2019. She could not recall if the 2019 attempted sleep study was initiated at a different facility than the 2018 study. -Client #3 had refused to have a sleep study completed. She did not have evidence or documentation client #3 refused appointments for sleep study in 2019. -Client #3's medical records had been purged and she was not sure if some information may have been in that filing system. -She reviewed client charts and records 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 291	<p>Continued From page 16</p> <p>often and felt this was an oversight.</p> <p>Review on 12/03/19 of the facility's Plan of Protection dated 12/03/19 and submitted by the Qualified Professional (QP) revealed:</p> <p>- "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?</p> <p>Effective today the QP will take responsibility for ensuring that the sleep study is scheduled. QP will also ensure that client gets to the appt (appointment). Should he continue to refuse then documentation will be obtained from the provider conducting the sleep study. Going forward the staff will be required to notify the QP of all follow up requested by any/all providers.</p> <p>- Describe your plans to make sure the above happens.</p> <p>QP will schedule the appointment. QP will also review recommendations and ensure immediate f/u (follow up) after all appts (appointments)."</p> <p>For over the past year, client #3 had a physician's order to have a sleep study conducted to rule out Sleep Apnea. During this timeframe, he had one unsuccessful attempt in August 2018. Since that time, no other documented attempt had been made to secure a sleep study. His recent Psychiatric visit supported behavioral concerns, no changes have been made to his medications until Sleep Apnea had been ruled out. This lack of service coordination is detrimental to health (physical and mental) of client #3 which constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 536	Continued From page 17	V 536		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <p>(1) knowledge and understanding of the people being served;</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 536	<p>Continued From page 18</p> <p>(2) recognizing and interpreting human behavior;</p> <p>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</p> <p>(4) strategies for building positive relationships with persons with disabilities;</p> <p>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</p> <p>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 536	<p>Continued From page 19</p> <p>by scoring a passing grade on testing in an instructor training program.</p> <p>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 536	<p>Continued From page 20</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of three audited staff (staff #2) had training in Alternatives to Restrictive Interventions. The findings are:</p> <p>Review on 12/03/19 of the facility's personnel records for staff #2 revealed: -Hired: 09/2019 -No evidence in training in Alternatives to Restrictive Intervention</p> <p>During an interview on 12/03/19, the Qualified Professional reported: -The Registered Nurse/Administrator maintained the personnel records and prepared the records for this survey -She was not aware staff #2 did not have alternative to restrictive intervention training in her record</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 736	Continued From page 21	V 736		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the home in a safe, attractive, orderly manner and free from offensive odor. The findings are:</p> <p>Observation on 11/21/19 at 5:30 PM revealed: -Upstairs living room- unused ladder against the wall, office chair with cushion on arms missing -Upstairs kitchen area-broken coffee pot, trash can lid missing flap door, hole in floor, wires exposed at bottom of coffee pot -Upstairs hallway near the bedrooms/bathrooms- no covering over lighting -Upstairs bedroom occupied by client #2- cluster of small pin-sized dark circular spots in the ceiling, crack noted near the window -Upstairs bedroom occupied by client #1 -strong odor noted, curtain rod broken -Upstairs bedroom occupied by client #5- string on ceiling fan too short for client to reach to operate overhead lighting and fan, crack in area between wall and ceiling, dust on wall -Upstairs bathroom- cracked toilet top and broken toilet paper holder, strong urine odor noted, light bulbs blown, ceiling plaster peeling</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 736	<p>Continued From page 22</p> <p>and vent rusted, -Stairway leading from upstairs- Uplifted nail noted in stripping -Downstairs hallway- ceiling stained throughout -Downstairs bathroom- dirty (toilet, vents shower and shower curtain), vanity/mirror missing bulb broken -Downstairs common area- ceiling stained from possible leak, ceiling uneven, baseboard wood rotted, couch inside cushion exposed, white stain on flooring and empty boxes piled up -Downstairs bedroom occupied by two clients (#4 & #3) - floor pieces missing, ceiling loose and shook when turned on, walls needed painted, ceiling fan dusty and space heater. -Downstairs bedroom occupied by client #6- not able to access because staff did not have key and client was unavailable</p> <p>During interview on 11/22/19, the Division of Health Service Regulation Construction Section Team Leader reported: -Space heaters in facilities of over 6 clients were a safety violation per building code -Per records, on 02/09/18, a survey was completed by the Construction Section. Although specific examples were different, the rule area Facility and Grounds Maintenance was cited. No plan of Correction had been received as a result of this survey</p> <p>During interview on 11/22/19 staff #1 stated she: -Was aware of some of the citations regarding the home because of previous surveys conducted at the home -She had lost the keys to the house a few months back and had not replaced the key to client #6's bedroom</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/06/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ABSOLUTE HOME - MARCONY WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 MARCONY WAY RALEIGH, NC 27610
--	--

(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 736	<p>Continued From page 23</p> <p>During interview on 12/03/19 the Qualified Professional reported:</p> <ul style="list-style-type: none"> -The Registered Nurse/Administrator was responsible for the overall maintenance and upkeep of the facility -She forgot the keys to client #6's bedroom were included in the misplaced key set. She would have that resolved by the week's end. -Prior to this interview, she was aware of some of the identified deficiencies <p>[The is a re-cited deficiency and required's a 30 day plan of correction]</p>	V 736		