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ABSOLUTE HOME-ROXBORO STREET	2826 SOUTH ROXBORO STREET DURHAM, NC 27707

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on April 29, 2021. The complaint was substantiated (intake #NC00176085). 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 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to assure one of one audited paraprofessional staff (Staff #5) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0604, INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (Tag V367). Based on record reviews and interviews, the facility failed to ensure Level II incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. Review on 4/16/21 of Client #1's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizophrenia; Hypothyroidism; Dyslipidemia. -He had a court appointed Guardian (his mother). Review on 4/16/241 of Client #2's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizoaffective Disorder, Bipolar Type; Gastroesophageal reflux disease; Allergic Rhinitis. Review on 4/16/21 of Staff #5's Personnel Record revealed:	V 110		

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V 110	Continued From page 2 -Hiring date of 9/17/20. -Staff #5 was hired as a Habilitation Technician. -Documentation of Special Populations training completed on 9/17/20. Review on 4/20/21 of the local law enforcement departments record of "Calls For Service" to the address of the facility from March 2021 through the survey date of April 21, 2021 revealed: -Law Enforcement was called on 3/9/21 to the house. Nature of the call was "Assault." No report made by Law Enforcement. -Law Enforcement was called on 4/1/21 to the house. Nature of the call was "Assault." Report made by Law Enforcement. -Law Enforcement was called on 4/4/21 to the house. Nature of the call was "Missing Person At Risk." Report made by Law Enforcement. -It was unknown who called law enforcement from the house. Interview on 4/16/21 with Client #1 revealed: -Client #1 was friendly and cooperative. He was alert, coherent, and oriented. -Client #1 reported having had an altercation with a fellow resident (Client #2) at the house a couple of weeks ago. He called the police and wanted to go to the hospital. -Police and Emergency Medical Services (EMS) arrived at the house. -Client #1 was transported to the hospital by EMS. -Client #1 stated: "The hospital did not want to keep me, so I walked out." -Client #1 spent a few days outside. He did not know what he wanted to do. He was afraid of coming back to the house because of situation with Client #2. -Client #1 reported that things were good now between them. They were getting along well.	V 110		

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-Client #1 reported walking the streets the days that he was out of the house and received food at a hotel.
-He walked to his mother's house.
-Mother returned him to the group home afterwards.
-He felt safe at the group home.
-He was getting along with everyone at the group home.
-He liked the staff at the group home.
-Client #1 did not want to elaborate incident of him being out of the house and walking around town.

Observation on 4/16/21 between 8:30 AM and 2:00 PM of Client #1 revealed:
-No bruises were observed on him.
-Frames of glasses were being held together at the corner with tape.
-He communicated and expressed himself well.

Interview on 4/19/21 with Client #1's mother revealed:
-She was Client #1's legal guardian.
-On Easter weekend, she had a cousin of Client #1 go to pick him up at the house.
-She had been trying to call the house prior to that to inform about them wanting to pick Client #1 up, but had not gotten through.
-When the cousin arrived, Staff #5 told him that he thought Client #1 was staying at his mother's.
-He was told that Client #1 had gone to the hospital after he and Client #2 had gotten into a fight.
-The family was not given the name of the hospital where Client #1 was taken.
-Mother telephoned Client #1's Assertive Community Treatment (ACT) Team. They called around and reported that Client #1 had been at a local hospital but was never admitted. Client #1

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had walked out of the facility. Whereabouts of Client #1 where unknown.
-Client #1's ACT Team called the group home for more information and initiated the missing person report.
-Staff #5 talked to her and told her that he thought Client #1 was with her.
-She reported that Staff #5 gave her an "unbelievable" story.
-Mother reported trying to call the owner of the facility, but never got through with her as there was never a response and her messages were not returned.
-When she called Client #1's ACT Team, she asked them if they knew anything about what had happened. They told her that they didn't. They had not received any information from Staff #5 about Client #1 being missing.
-The ACT Team had called the police. It seemed that Client #1 may have been discharged by the hospital without ever admitting him.
-Mother reported sending a picture of her son via email to the missing person report.
-She had received a police report reference number:
-Client #1 showed up at her house the day after the missing person report was filed. He looked tired.
-Police came to the house and took him off the missing person list.
-Client #1 told her that he was worried about returning to the group home. He also told her that he had been hit in the face.
-When she asked him why, he told her that he had taken someone's soda.
-She had to take Client #1 back to the group home because she could not care for him at her house.
-She met with Staff #5 and was told that he would take care of things and that Client #1 would be

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safe at the house.
-The Owner called her this past weekend and asked her why she never contacted her?
-Mother reported that she had tried to contact her. She called and never received a response back.
-The Owner told her that she did not know anything about this happening and that Client #1 had gone missing. No one ever told her anything.

Interviews on 4/16/21 and 4/20/21 with Staff #1 revealed:
First interview dated 4/16/21:
-He worked full time at the facility.
-He was a live-in staff. He stayed and worked at the house for two weeks and would be off the following week.
-Initially denied having had any recent incidents at the house.
-No incident reports were written by him.
-Reported minor argument between some of the residents at the house.
-Client #1 and Client #2 had an incident. "There was pushing and shoving between the two. Everything is well now between them. Nobody got hurt."
-Staff was able to diffuse things between the clients at the house.
-He denied any residents being hospitalized recently.
-Staff #1 then reported that on the incident between Client #1 and #2, Client #1 had called the police and they came to the house.
-Staff #5 then acknowledged that Client #1 was transported to the hospital by Paramedics and Police.
-Later in the evening, Police came to the home to ask if anyone wanted to file any charges. Police informed him that Client #1 was still at the hospital and that his mother was going to pick him up.

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V 110	Continued From page 6 -He initially did not have Client #1's guardian's phone number, but got it from his cousin later. -He telephoned and spoke with Client #1's guardian. She reported that everything was fine and that Client #1 was going to stay with her a couple of days and she would bring him back afterwards. -Staff #5 believed there may had been some confusion with the police and the hospital. He believed the police thought that Client #1 was at a different kind of group home on which he could come and go as he wished. -Staff was under impression that Client #1 was at his mother's the whole time. -Staff reported also he had contacted Client #1's ACT Team the night of the incident and they too had been aware of what had happened. -Staff acknowledged he never made an incident report. -Staff reported that he had no idea about Client #1 being missing. He thought he was at his mother's house. The hospital never called him about Client #1 being discharged. Second interview on 4/20/21: -Staff reported that Client #1 and #2 had gotten into an argument. Client #1 called police. Client #1 was taken to the hospital. -Police showed up later to see if charges needed to be drawn. "Client #1 was fine. Client #2 was fine. Nothing happened to anyone." -He thought Client #1 was at the hospital. -He did not call Client #1's mother. Reported that he did not have her contact information. -He got the number from Client #1's cousin when he went to the house looking for him. -Staff reported that it had been two days before he knew that Client #1 was not at his mother's. -On Easter Sunday, Client #1's ACT Team contacted him and that's when he knew that a	V 110		

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missing person report was going to be made.
-Staff #5 reported that when police initially came by the house to see about filing charges, he was told that Client #1 was at the hospital and that he was fine. He did not know that he was going to be released by the hospital.
-He acknowledged not doing an incident report.
-He acknowledged not contacting the Qualified Professional, Supervisor or the Owner once he learned that Client #1 had gone missing.
-Client #1's ACT Team did the missing person report.

Interview on 4/21/21 with Client #1's ACT Team leader revealed:
-She reported that Client #1's mother called their Crisis line during the weekend of Easter.
-Client #1's mother reported that a family member had gone to pick up Client #1 for Easter weekend and was told that he was not at the house and that he had gone to the hospital.
-Client #1's mother was concerned.
-ACT Team called the hospital and were told that Client #1 was triaged out and he had left on his own.
-They called Staff #5 at the house and he did not know what to do.
-Staff #5 told them that he never called the hospital and the hospital also never called him.
-Staff #5 did not initiate the missing person report.
-Missing person report was made by the ACT Team. A report was made.
-Nobody knew where Client #1 was. He showed up at his mother's house the day after the missing person report was made.
-They spoke with Client #1 and he told them that he basically walked around town and had gotten food from a hotel.
-They went and met with Client #1. He seemed well and did not show any signs of

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decompensation.
-Client #1 was a very smart, high functioning individual.
-They had been working with him for a while and believed that he was able to live on his own.
-He had been very stable since he had been on treatment.
-Client #1 was capable of finding employment and knew his way around town.

Interview on 4/16/21 with the House Supervisor revealed:
-She came to the house about once or twice a month.
-She checked up on the house and residents, needs at the house, medications and records.
-She did not know that Client #1 had gone missing.
-Staff #5 never told her that Client #1 was missing.

Interview on 4/16/21 with the Qualified Professional revealed:
-She was not aware that Client #1 had ever been missing during Easter weekend.
-Staff #5 had told her that he had contacted Client #1's team and things were OK.
-Staff #5 had minimized the situation to her.
-She also thought the Owner had spoken with Client #1's mother.
-She reported if she would have known, she would have filed a missing person alert.
-Staff #5 never mentioned to her that Client #1 was missing.
-This was all new to her.
-She was on vacation for Easter weekend, but she would have followed up even though she was out of town.

Interview on 4/20/21 with the Owner revealed:

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V 110	Continued From page 9 -She did not know anything that happened at the house. -She did not know that Client #1 had gone missing. -She was never informed of anything. -The first time she found out that something happened at the house was during the time of this survey when questions were being asked about events on Easter weekend. -She telephoned Client #1's mother after hearing about it. She usually had good communication with Client #1's mother. -She found it weird that Client #1's family wanted to pick him up during COVID times. -Residents at the house had not been allowed to go to their family's homes due to the pandemic. -Owner reported that Client #1 was a very smart person and that he knew his way around. He knew Durham well. -Client #1 used to drive and had a job. Client #1 knew how to get to his mother's home. -Client #1 had not history of going missing before. -She confirmed Staff #5 failed to do what he was supposed to do when Client #1 went to the hospital. Review on 4/21/21 of the Plan of Protection submitted by the facility's Owner revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? -"The Qualified Professional will complete training on client supervision, honest communication and criteria for incident reporting within the next 24 hours. The Qualified Professional and Supervisor will do daily check in with the staff person. This time will be used to focus on any unusual occurrences for that day. This might include illness, injury, police involvement, elopement, client interactions or any unusual event. This will be documented on the daily communication log."	V 110		

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V 110	Continued From page 10 Describe your plans to make sure the above happens: -"The administrator will meet with the Qualified Professional and Supervisor at least weekly to discuss how staff is following through and demonstrating skills necessary to fulfill requirements of the job." On April 1, 2021, Client #1 had gotten into a verbal and physical altercation with Client #2. Local law enforcement and EMS were called to the facility and after arriving Client #1 requested to go to the hospital where he was transported alone while Staff #5 stayed at the group home. Once Client #1 got to the hospital, Staff #5 failed to follow-up with hospital staff regarding Client #1's status. Client #1 was not admitted to the hospital after being assessed and was discharged. The hospital attempted to contact the facility but were unsuccessful. Client #1 left the hospital and was missing for 5 days. Staff #5 did not contact or follow-up with the hospital on the status of Client #1. Staff #5 did not communicate and report to the Facility Owner, House Supervisor, Qualified Professional, legal guardian, and ACT Team about Client #1 going to the hospital, which resulted in client #1 leaving the hospital and being missing. Staff #5 also failed to report the altercation between Client #1 and Client #2 and to complete and submit an incident report for the incident. Staff #5 also failed to report and initiate a missing person report for Client #1, resulting in the ACT Team reporting Client #1 missing after it was reported to them by Client #1's legal guardian. The ACT Team reported that Staff #5 did not know what to do regarding Client #1 being missing. This deficiency constitutes a Type A1 rule violation for serious neglect and must be	V 110		

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V 110	Continued From page 11 corrected within 23 days. An administrative penalty of $2,000 is imposed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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.	V 112		

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V 112	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have a Person Centered Plan with 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 affecting two of three audited clients (#1, #2). The findings are: Review on 4/16/21 of Client #1's record revealed the following: -Admission date of 2/11/19. -Diagnoses of Schizophrenia; Hypothyroidism; Dyslipidemia. -Client #1's Person Centered Plan had goals identified. -Client #1's Person Centered Plan was signed by the Qualified Professional. -Client #1's Person Centered Plan was not signed by his legal guardian. Review on 4/16/21 of Client #2's record revealed the following: -Admission date of 9/1/20 -Diagnoses of Schizoaffective Disorder, Bipolar Type; Gastroesophageal reflux disease -Client #2's Person Centered Plan had goals identified. -Client #2's Person Centered Plan was signed by the Qualified Professional. -Client #2's Person Centered Plan was not signed by his legal guardian. Interview on 4/16/21 with the Director/Qualified Professional revealed: -She was responsible for completing the Person Center Plans.	V 112		

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V 112	Continued From page 13 -She had finished updating the Person Centered Plans for Clients #1, #2, but their guardians had not signed them yet. -She confirmed Clients #1 and #2, Person Centered Plans had not been signed by their legal guardians.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills on every shift at least quarterly. The findings are: Review on 4/16/21 of the facility's fire and disaster drills record revealed: -There were no fire drills log available for review. -There were no disaster drills log available for review.	V 114		

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V 114	Continued From page 14 Review on 4/16/21 of fire and disaster drills faxed to surveyor's office revealed: -Drills belonged to a sister facility. -Drills did not have the actual name of the group home listed. Interview on 4/16/21 with Staff #1 revealed: -He could not find any records at the house. -There were no logs available at the house to be reviewed. Interview on 4/16/21 with the Qualified Professional and the Supervisor revealed: -They believed that drills had not been conducted at the house this past year. -They confirmed a fire and disaster drills log was not easily available at the time of the survey. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (4) A Medication Administration Record (MAR) of	V 118		

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V 118	Continued From page 15 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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep the Medication Administration Record (MAR) current affecting two of three Clients (#1 and #2). The findings are: Review on 4/16/21 of Client #1's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizophrenia, Hypothyroidism; Dyslipidemia Review on 4/16/21 of Client #1's physician's orders revealed: -Orders dated: 2/24/20 -Clozapine 200 milligrams (mg)- Take two tablets at night. -Orders dated: 3/31/21 -Metformin 500 mg- Take two tablets daily.	V 118		

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V 118	Continued From page 16 -QC Vitamin B12 1000mg- Take one tablet at night. Observation on 4/16/21 at 12:40 P.M. of Client #1's medications revealed: -All medications were available. Review on 4/16/21 and 4/20/21 of Client #1's MAR for April 2021 revealed no blanks on the following dates: -Clozapine 200 - 4/1/21-4/5/21 -Metformin 500 mg- 4/1/21-4/5/21 -QC Vitamin B12 1000mg- 4/1/21-4/5/21 -Staff signed medicines as given, but client was not at the facility from 4/1/21-4/5/21. Review on 4/16/241 of Client #2's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizoaffective Disorder, Bipolar Type; Gastroesophageal reflux disease; Allergic Rhinitis. Review on 4/16/21 of Client #3's physician's orders revealed: -Orders dated: 11/19/20 -Trazodone 150 mg- Take two tablets at night. Observation on 4/16/21 at 12:50 P.M. of Client #2's medications revealed: -Medication was available. Review on 4/16/21 of Client #2's MAR for February 2021 through April 2021 revealed blanks on the following dates: -Trazodone 150 mg- 4/1/21-4/15/21. Interview on 4/16/21 with Clients #1 and #2 revealed:	V 118		

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V 118	Continued From page 17 -They took their medicines as prescribed. -They had never had any problems receiving their medicines from staff. Interview on 4/16/21 with Staff #1 revealed: -He was not aware there were blanks on Client #2's MAR. -He thought that if he gave the medicines to Client #1's mother to take home, he would have to mark them as given. -He was not aware that he needed to make special notation on the MAR whenever the client was not present at the home. -Staff was observed correcting the MAR for Client #2 and signing on dates that had been left blank. -He acknowledged that he had made a mistake on the MAR and failed to keep it current for Clients #1 and #2. Interview on 4/16/21 with the House Supervisor revealed: -She was responsible for reviewing MAR's and medications monthly. -She was not aware that staff had marked the MAR wrongly for Client #1 while he was out of the facility. -She was not aware that staff had blanks in the month of April for Client #2's MAR. -She confirmed facility staff failed to keep MAR's current for Clients #1 and #2.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the	V 367		

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V 367	Continued From page 18 consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident.	V 367		

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V 367	Continued From page 19 (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 4/16/21 of Client #1's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizophrenia; Hypothyroidism; Dyslipidemia. -There were no incident reports in Client #1's record. Review on 4/16/241 of Client #2's record revealed: -Admission date of 2/11/19. -Diagnoses of Schizoaffective Disorder, Bipolar Type; Gastroesophageal reflux disease; Allergic Rhinitis. -There were no incident reports in Client #2's record. Review on 4/16/21 of Staff #5's Personnel Record revealed: -Hiring date of 9/17/20. -Staff #5 was hired as a Habilitation Technician. Review on 4/20/21 of the local law enforcement departments record of "Calls For Service" to the address of the facility from March 2021 through the survey date of April 21, 2021 revealed: -Law Enforcement was called on 3/9/21 to the house. Nature of the call was "Assault." No report made by Law Enforcement. -Law Enforcement was called on 4/1/21 to the house. Nature of the call was "Assault." Report made by Law Enforcement.	V 367		

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V 367	Continued From page 21 -Law Enforcement was called on 4/4/21 to the house. Nature of the call was "Missing Person At Risk." Report made by Law Enforcement. -It was unknown who called law enforcement from the house. Review on 4/16/21 of the North Carolina Incident Response Improvement System revealed: -There was no documentation of any Level II incidents happening at the group home from June 2020 through the survey date April 21, 2021. -There was no documentation regarding what may had happened at the group home that warranted local law enforcement to be called on 3/9/21, 4/1/21 and 4/4/21. Review on 4/26/21 of the facility's incident reports folder revealed: -There were no incident reports to review. -There was no documentation regarding what may had happened at the group home that warranted local law enforcement to be called on 3/9/21, 4/1/21 and 4/4/21. -There was no documentation regarding incident on 4/1/21 between Client # and Client #2. -There was no documentation that Client #1 was or had been missing. Interview on 4/16/21 with Client #1 revealed: -Client #1 reported having an altercation with a fellow resident (Client #2) at the house a couple of weeks ago. He called the police and wanted to go to the hospital. -Police and Emergency Medical Services (EMS) arrived at the house. -Client #1 was transported to the hospital by EMS. -He was never hospitalized, walked out the hospital and spent a few days walking around town.	V 367		

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V 367	Continued From page 22 Interview on 4/19/21 with Client #1's mother revealed: -On Easter weekend, she had a cousin of Client #1 go to pick him up at the house. -He was told that Client #1 had gone to the hospital after he and Client #2 had gotten into a fight. -Mother telephoned Client #1's Assertive Community Treatment (ACT) Team. They called around and reported that Client #1 had been at a local hospital but was never admitted. Client #1 had walked out of the facility. Whereabouts of Client #1 where unknown. -Client #1's ACT Team called the group home for more information and initiated the missing person report to the police. Interviews on 4/16/21 and 4/20/21 with Staff #1 revealed: First interview dated 4/16/21: -He was a "live-in" staff. He worked for two weeks and was off the following. -Initially denied having had any recent incidents at the house. -No incident reports written. -Reported minor argument between some of the residents at the house. -Client #1 and Client #2 had an incident. "There was pushing and shoving between the two of them. Everything was well now between them. Nobody got hurt." -Staff were able to diffuse things between clients at the house. -He denied any residents being hospitalized recently. -Staff #1 then reported that with the incident between Client #1 and #2, Client #1 had called the police and they came to the house. -Staff #5 then acknowledged that Client #1 was	V 367		

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V 367	Continued From page 23 transported to the hospital by Paramedics and Police. -Staff acknowledged he never completed an incident report. Second interview on 4/20/21: -Staff reported that Clients #1 and #2 had gotten into an argument. Client #1 called police. Client #1 was taken to the hospital. -He thought Client #1 was at the hospital. -Staff reported that it had been two days before he knew that Client #1 was not at his mother's. -He acknowledged not doing an incident report. Interview on 4/16/21 with the House Supervisor revealed: -Staff #5 never let her know that Client #1 was missing. -She acknowledged that Staff #5 should have completed an incident report and informed her and the Qualified Professional about what happened. Interview on 4/16/21 with the Qualified Professional revealed: -She was not aware that Client #1 had ever been missing during Easter weekend. -She acknowledged that Staff #5 should have completed an incident report and informed her and the Supervisor about what had happened, especially since police and EMS were called to the house. Interview on 4/20/21 with the Owner revealed: -She did not know anything happened at the house. -She did not know that Client #1 may have gone missing. -She was never informed of anything. -The first time she found out that something	V 367		

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V 367	Continued From page 24 happened at the house was during the time of this survey April 21, 2021 when questions were being asked about events on Easter weekend. -She confirmed that Staff #5 failed to communicate with others regarding what happened with Client #1 and did not complete an incident report when local law enforcement and EMS showed up at the house, when Client #1 went to the hospital nor when Client #1 was missing. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110) for a Type A1 and must be corrected within 23 days.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are: Observation on 4/16/21 at 9:30AM of the outside of the house revealed: -There was a car tire leaning against the shed.	V 736		

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V 736	Continued From page 25 -Dismantled camping tent in the back porch. -Grass in front of house was tall and in need for mowing. -There were two unusable black chairs between bushes in front of the house. Observation on 4/16/21 at 11:02 AM of the Kitchen revealed: -Several cracked tiles throughout the kitchen area. -Fire Extinguisher in kitchen area was expired. Label stated that it expired on 9/2020. Observation on 4/16/21 at 11:05 AM of the Dining area revealed: -Blinds on window were missing two sections. Observation on 4/16/21 at 11:08 AM of the Living area revealed: -Big window was missing two blinds. Observation on 4/16/21 at 11:10 AM of Client's bathroom #1 revealed: -Floor seemed to be caving in. -There was a loose floor tile outside the shower. -Medicine cabinet did not fully close. Observation on 4/16/21 at 11:12 AM of the Hallway revealed: -Section outside bathroom seemed to be caving in. -Fire Extinguisher in hallway was expired (9/2020). Observation on 4/16/21 at 11:15 AM of Client #1's bedroom revealed: -Dresser was missing the front of the top drawer. Observation on 4/16/21 at 11:17 AM of the Client's bathroom #2 revealed:	V 736		

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V 736	Continued From page 26 -Panel underneath window was lose and coming off. -Mold/Mildew was observed along the edges between the tub and the wall. Interview on 4/21/21 with the Owner revealed: -Her agency was responsible for doing maintenance for the home. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the facility water temperature between 100-116 degrees Fahrenheit. The findings are: Observation of the facility on 4/16/21 between 11:00 AM and 11:17 AM revealed: -Kitchen sink water temperature was 120 degrees Fahrenheit.	V 752		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME-ROXBORO STREET	2826 SOUTH ROXBORO STREET DURHAM, NC 27707

(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 752	Continued From page 27 -Bathroom #1 water temperature was 118 degrees Fahrenheit. -Bathroom #2 water temperature was 108 degrees Fahrenheit. Interview on 4/16/21 with Staff #1 revealed: -He felt the water was never warm enough at the bathrooms. -He was surprised to see the temperature at the kitchen sink. -Residents were high functioning individuals. -Residents were able to adjust water temperatures themselves. -Hot water fluctuated around the house and at different times. The furthest from the water heater, the less hot it would be. -He confirmed the facility failed to maintain the facility water temperature between 100-116 degrees Fahrenheit.	V 752		