Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
701012701	or connection	IBENTIN IO/ WIGHT NOMBER.	A. BUILDING: _		
		MHL092-878	B. WING		C 05/12/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
ABSOLU1	TE HOME #5		D MILL ROAD , NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS	;	V 000		
	Complaint Intake # 00 unsubstantiated. Defi	ciencies were cited. d for the following service 27G .5600A Supervised			
V 113	27G .0206 Client Red	cords	V 113		
	(a) A client record shaindividual admitted to contain, but need not (1) an identification far (A) name (last, first, right) client record num (C) date of birth; (D) race, gender and (E) admission date; (F) discharge date; (2) documentation of developmental disability diagnosis coded according (3) documentation of assessment; (4) treatment/habilitating (5) emergency informshall include the name number of the person sudden illness or according as included the number of the person sudden illness or according as included the number of the person sudden illness or according as included the number of the person sudden illness or according the person gemergency care from (7) documentation of	mental illness, lities or substance abuse ording to DSM IV; the screening and cion or service plan; nation for each client which e, address and telephone to be contacted in case of ident and the name, address er of the client's preferred out from the client or legally ranting permission to seek a hospital or physician;			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		MHL092-878	B. WING		C 05/12/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ABSOLUT	E HOME #5		D MILL ROAD		
7.200201		GARNER	, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 113	Continued From page	÷ 1	V 113		
	(A) documentation of diagnosis according to Diseases (ICD-9-C (B) medication orders (C) orders and copies (D) documentation of administration errors (b) Each facility shall relative to AIDS or relonly in accordance with the diagnostic of the diag	physical disorders o International Classification M); s; s of lab tests; and medication and and adverse drug reactions. ensure that information ated conditions is disclosed			
	discharge summaries (#1, #2, #3, #4 & #5). -During interview on 4 Professional (QP) states -Staff #1 passed aware home. -They moved the client was no staff to send of -All clients were moved -They moved the client until they can get a states -This move is just term them back in the home.	the facility failed to complete for five of six former clients. The findings are: 4/15/21 the Qualified ted: y 3/28/21 at the group hts that day because there over to the home. ed to sister facilities. hts to two different homes aff hired. hporarily, hopefully will have be next week. charge summaries as they "not officially discharged."			
		n moved back to the home.			

Division of Health Service Regulation

-They have not hired a new staff yet.

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		MHL092-878	B. WING		0.5	C / 12/2021
NAME OF P	ROVIDER OR SUPPLIER		I DDRESS, CITY, STAT	F ZIP CODE	1 00	11212021
			D MILL ROAD	L, ZII 000L		
ABSOLUI	E HOME #5	GARNER	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 113	Continued From page	e 2	V 113			
	-Hopefully will be moweek.	ving them back in the next				
V 512	27D .0304 Client Rig	hts - Harm, Abuse, Neglect	V 512			
	(a) Employees shall abuse, neglect and e with G.S. 122C-66. (b) Employees shall sort of abuse or negle 27C .0102 of this Cha (c) Goods or service purchased from a clie established governing (d) Employees shall necessary to repel or aggressive client and governing body policy is necessary depends characteristics of the and physical and mel of aggressiveness disintervention procedur Subchapter 10A NCA (e) Any violation by a	protect clients from harm, exploitation in accordance not subject a client to any ect, as defined in 10 A NCAC apter. Is shall not be sold to or ent except through g body policy. It is only that degree of force is ecure a violent and is which is permitted by yy. The degree of force that is upon the individual client (such as age, size intal health) and the degree splayed by the client. Use of ees shall be compliance with acc 27E of this Chapter. In employee of Paragraphs Rule shall be grounds for				
	Review on 4/15/21 of	EC #7's record revealed:				

Division of Health Service Regulation

STATE FORM 6899 L6QT11 If continuation sheet 3 of 14

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL092-878	B. WING		05/12/2021
					1 00:12:2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
ABSOLUT	E HOME #5		D MILL ROAD		
		GARNER	, NC 27529		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG			IAG	DEFICIENCY)	
		_	1		
V 512	Continued From page	÷ 3	V 512		
	-Admission date of 10)/20/20.			
	-Diagnosis of Schizop				
	-Discharge date of 2/2				
	· ·				
	During interview on 4	/21/21 FC #7's grandmother			
	stated:				
	-FC #7 went to jail a f	ew months ago while living			
	in the facility.				
		ned the home would not			
	bail him out.				
		s stimulus money and would			
	not use it to bail him o				
		hrough a private agency			
	who was over his mor	from jail and went to the			
	group home to retriev				
	• .	ent to the group home and			
		and money, but they just			
	gave him his clothes				
	-Not sure where FC #	<u>-</u>			
		w weeks ago and said he			
	was at a homeless sh	elter and sleeping on the			
	floor at another location	on.			
	-FC #7 will not stay in	a place that makes him			
	follow rules.				
	5 · · · · 5	10/04			
	_	/3/21 a representative from			
	FC #7's payee agenc				
	-Their agency became December 2020.	e payee or FC #7 IN			
		ving in the facility when they			
	were named payee.	ving in the facility which they			
		nsee there was a balance			
	on his account and ne				
		n 12/15/2020 for "cost of			
	· ·) was also made out to them			
		or his spending money.			

care."

-Paid January 15, 2021 \$570.50 for "cost of

-Paid February 3, 2021 \$570.50 for "cost of care."

STATE FORM 6899 If continuation sheet 4 of 14 L6QT11

Division of	of Health Service Regu	lation			FORM	APPROVED	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:	` '		COMPL		
			_			_	
			B. WING		C		
		MHL092-878			05/1	12/2021	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE			
ABSOLUT	TE HOME #5		D MILL ROAD				
		GARNER	, NC 27529	T.			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE	
IAG			IAG	DEFICIENCY)	=		
V 512	Continued From page	e 4	V 512				
	-Paid March 3, 2021 9	\$570.50 for "cost of care."					
	-	ets \$382.00 because he was					
	in jail.						
	1 ,	suspended because he was					
	incarcerated for more						
		stimulus money on 4/7/21					
	and they still have it in						
	_	s money distributed in					
	January 2021, was no						
		ve been sent to his previous					
		have forwarded it to the					
	Licensee.						
	-Not aware of where I	FC #7 is currently living.					
	-He will call in the mid	dle of the night from					
	random numbers requ						
	_	mbers back and are told, FC					
	#7 was just using thei						
	I	account and would send it					
	to him if they had a lo						
		nd maintain his money.					
		th facility's process of					
		ing Special Assistance (SA)					
	funding.						
		completed by the facility					
		epartment of Social Services					
	(DSS) of the county the						
		ormation from the facility or					
	county DSS regarding						
		ount of money received by					
		by Social Security, not the					
	payee.	a that the naves sould					
	1	g that the payee could					
	change.		1			1	

for FC #7.

-Was not aware the facility was not receiving SA

-SA funding is between the facility and the county

Department of Social Services (DSS).

-They have nothing to do with SA, because it

-Since finding out FC #7 was discharged in

goes to the facility for their care.

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Division of	of Health Service Regu	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					l c	
		MHL092-878	B. WING		1	2/2021
		WITE032-070			1 03/1/	2/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
A PSOLUT	E HOME #5	201 RAN	D MILL ROAD			
ADJULU I	E NOIVIE #3	GARNER	, NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG		200 152.11.11 1.11.0 1.11 2.11.5.1.5.1.5	IAG	DEFICIENCY)	WALE	
\/.540	r	_	77.540	 		
V 512	Continued From page	∍ 5	V 512			
	February 2021 and th	ney had sent her \$570.50 for				
		ch 2021, this money needed				
	to be refunded to his	•		İ		
	-Called the Licensee	on March 18, 2021 to				
	request March 2021 r					
	-The Licensee stated	she would check her				
	records and get back					
	_	April 6 2021, and no answer.		İ		
		on April 21, 2021 she		İ		
		on as she found out what				
	_	she said, "I'm not discussing				
	this with you" and hur			İ		
		call back, the call went to				
		nail was full so she could not		İ		
	leave a message.			İ		
		om the Licensee at this				
	point.					
	During interview on 4	/20/21 the Licenses stated:				
	_	/28/21 the Licensee stated: stimulus payment \$1207.00				
	or \$1107.00, "he got			İ		
		ey to her, so they could		İ		
		oney for FC #7 to use.				
	· · · · · · · · · · · · · · · · · · ·	noney was still there, he was				
	supposed to call her b			İ		
		inted \$200.00 to use for a		İ		
		she was not sure if he had		İ		
	enough money in his					
	-FC #7 was admitted					
		payee, but told him to let her				
	be his payee.			İ		
		ner to be his payee because		İ		
	he did not want them	over his money.				
	-Never received SA for					
	-Had applied for SA, I	but was never approved.				
	-FC #7 was not receive	ving SA prior to his				
	admission.					
	-SA representative to	old her FC #7 did not qualify				
	because they needed	d him to increase to full				

benefit a month before DSS would approve the

STATE FORM 6899 L6QT11 If continuation sheet 6 of 14

Division of Health Service Regulation				1 Orav	IAITROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					c	:
		MHL092-878	B. WING		ı	2/2021
NAME OF D		CTDEET A	DDDECC CITY CTA	TE 7/D 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE		
ABSOLUT	E HOME #5		D MILL ROAD			
			R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512	Continued From page	6	V 512			
	SA benefit.					
		Itiple times and no one ever				
	returned her call.	tupic unies and no one ever				
		I to be the ones to send				
		nake sure he was eligible				
		a one time payment "of				
	about \$1200.00," then	n after that \$570.00 for two				
	months.					
		4.00 in December 2020,				
		e months \$570.00, \$570.00				
	and \$636.00					
		timulus money which was				
	\$1207.00.	ne left, he never paid us the				
	full amount when he					
	-He still owed them m					
		d one time to see what				
		ved and she told them she				
	•	ee what he owed them and				
	what he had left.					
	-Since she was not hi	s payee, she could not				
		he owed her back pay.				
	•	ient did not help her get SA				
	then she would discha	•				
	* ·	s with FC #7 to get him to				
		yee so the process to apply				
	for SA would go easie	ਰਾ. February 2021, and his				
	grandmother wanted					
	-"I don't bail anyone o					
		he money in his account to				
	use for bail.	is money in the decoding to				
		t she is payee for and they				
	have not had these is	· ·				
		full benefits a month, so				

be done.

that was the problem with SA.

-Made multiple calls to SA to see what else could

-Did admit him knowing he did not receive SA. -Admit people all the time not receiving SA, but

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Division of Health Service Regulation

DIVISION	or riealin Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	_ETED
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			D. WING		l l	C
		MHL092-878	B. WING		05/	12/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			MILL ROAD			
ABSOLUT	E HOME #5					
		GARNER,	NC 27529	_		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOPE REFERENCED TO THE AR		COMPLETE DATE
TAG	REGULATORT OR I	LOC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DAIL
			+	,		
V 512	Continued From page	e 7	V 512			
	apply for it and get it	•				
	_	a thirty day notice prior to				
	going to jail.					
	_	as the end of February				
	2021.					
		021 money from payee and				
		wed them money since they				
	did not receive SA du	9				
		ney left to return to payee				
	because it was all use					
	-Holding him account	able to the SA funds she did				
	not receive during his	stay.				
	-FC #7 has not contact	cted her back to see what				
	he owes her.					
		vas sent to the Licensee				
		s admission forms. The				
		"Hi, I just remember, [FC				
	#7] never signed his p	paperwork when he was				
	admitted. I approach	ed him couple of times				
	about signing and he	said he doesn't plan to be				
	there long and doesn	't want anything to hold him				
	when he is ready to le	eave. Even though I				
	explained that it will n	ot hold him but he still				
	refused to sign them.	n				
	During interview on 5	/4/21 the County Adult				
	Medicaid Supervisor	stated:				
		ompleted for FC #7 in the				
	system on 11/25/20.	•				
	_	denied due to an open				
		rland County dated July,				
	2020.	3				
		e staff spoke to the facility				
		Security Income (SSI), after				
		ke staff realized FC #7 had				
		in another county, therefore				
	it was denied	in another country, therefore				
		the payee was for the				
	-it doesn't matter who	uie payee was iti lile	1	1		1

Division of Health Service Regulation

client, that would not have affected the denial.

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ABSOLUTE HOME #5 CAN DESCRIPTION OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 8 -Denial for SA was based on an open application in another county. Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed: DATE STREET ADDRESS, CITY, STATE, ZIP CODE 201 RAND MILL ROAD GARNER, NC 27529 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 512 V 512 Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
ABSOLUTE HOME #5 CARNER, NC 27529 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 8 -Denial for SA was based on an open application in another county. Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed: CX5) PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 512 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS			MHL092-878	B. WING		C 05/12/2021
ABSOLUTE HOME #5 GARNER, NC 27529 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 8 -Denial for SA was based on an open application in another county. Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed: CX5) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORR	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 8 -Denial for SA was based on an open application in another county. Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed:	ABSOLUT	TE HOME #5				
-Denial for SA was based on an open application in another county. Review on 4/30/21 of the facility's "Client Fees for Services," policy revealed:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE
"Client fees for services, if applicable, will be determined jointly by Absolute Home and Community Services and the contracting Area Authority. -In cases involving fees for client services that are to be reimbursed by a third party such as Medicaid and private pay. -Other payments can be SSI, SA and SIClients shall be charged a minimum fee for room and board" Review on 4/30/21 of facility's "Adult Homes Rules and Regulations" revealed: ""Residents are responsible for paying for their room and board, which is \$1182.00 and are also responsible for paying for the co-payments of medications" Review on 5/5/21 of facility's "Payment Record" for FC #7 revealed: -"December 2020- \$1364.00 -January 2021- \$570.00 -February 2021- \$570.00 -March 2021- \$636.00 -Balance from stimulus \$404.00 -Total received \$3544.00 -Amount Owe -October 2020- \$457.55 -November 2020- \$1182.00 -December 2020- \$1182.00 -January 2021- \$1182.00	V 512	-Denial for SA was bain another county. Review on 4/30/21 of Services," policy reversities of service determined jointly by Community Services Authority. In cases involving feet to be reimbursed by a Medicaid and private -Other payments can -Clients shall be charged and board" Review on 4/30/21 of Rules and Regulation -"Residents are resproom and board, which responsible for paying medications" Review on 5/5/21 of for FC #7 revealed: -"December 2020-\$1 -January 2021-\$570February 2021-\$570February 2021-\$570February 2021-\$636.00 -Balance from stimuluing -Total received \$3544 -Amount Owe -October 2020-\$11 -December 2020-\$11 -December 2020-\$11 -December 2020-\$11 -December 2020-\$11	the facility's "Client Fees for aled: ces, if applicable, will be Absolute Home and and the contracting Area es for client services that are a third party such as pay. be SSI, SA and SI. ged a minimum fee for room facility's "Adult Homes so revealed: consible for paying for their this \$1182.00 and are also go for the co-payments of facility's "Payment Record" 364.00 000 000 000 000 000 000 000	V 512		

Division of Health Service Regulation

-Total owe \$4, 932.26

-\$4932.26-\$3544.00, still owe balance of

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STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL092-878	B. WING		C 05/12/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ARSOLUI	E HOME #5	201 RAN	D MILL ROAD		
ABSOLU	E HOWE #3	GARNER	R, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 512	Continued From page	9	V 512		
	\$1382.00"				
	During further intervies 5/11/21 the Licensee -FC #7 received \$120 sure where the mone a copy of that checkFC #7 had \$404.00 obelonged to him, but what he owes to them -"If he were to call for give it to him, if he ha -Was not aware of the received from Social admittedKnew he did not hav applied for it when the admissionIf they apply for SA a is the clients responsifeeIn the case of FC #7 her to be his payee so SA issues, "This is his -The client is responsified he had not dischar have discharged himThey are keeping his received from payee the back pay." -He was aware that m would have been app -"This is his responsit was asked how client owed when the SA was aware he did not -"He stayed at my hot stayed seven days a stay	of that money left that the is responsible for paying in. some money, we would dany left." e amount of money he Security when he was ee SA, which she always ey did not have it at and they do not receive it, it it it it it to pay that remaining in, all he had to do was allow to she could take care of the is fault." iible for his room and board. If it is is it is is it is it is it is it is it is it is it is it is it is it is is it is it is it is it is it is it is is it is it is is it is is it is is it is is it is is it is is it is is it is is is it is i			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.			
		MHL092-878	B. WING		C 05/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ARSOL LIT	E HOME #5	201 RAND	MILL ROAD			
ADOOLOI	E HOME #0	GARNER,	NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 512	Continued From page	: 10	V 512			
V 512	-The SA representative were both lying about her and FC #7's reasongular and FC #7's reasongular and FC #7's reasongular and FC #7's reasongular and FC #7's reasongular and FC #7's reasongular and FC #7's reasongular and FC #7's money to the Paragraph of the Pa	their communication with on for not receiving SA. ing on me." dence with the Payee and show she had tried SA approved. ot sign his admission so that meant he should be by back. I am not doing this. ot taking a Type A for this." used to say it was FC #7's k pay" of \$1182.00 a month ant me to give you?" When y additional information the rovide. Sked to complete a Plan of I she did not do anything 21 at 2:45pm: sional (QP) asked the ed to include returning FC yee as part of the plan, the	V 512			
	on client room and bo facility will update the	policy to reflect the process determine client's eligibility				
	for continued admissi	ons to the group home. The				

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a person is designated to be responsible for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		· ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL092-878	B. WING		0.5	C 5/12/2021
NAME OF B			ADDESS CITY STATE	ZID CODE	1 00	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE D MILL ROAD	, ZIP CODE		
ABSOLUT	ΓE HOME #5		, NC 27529			
0/10/15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 512	Continued From page	2 11	V 512			
V 512	paying that fee. This member or the client. that a person has not requirements within 6 (60 for IDD home) will-Describe your plans happens. -The administrate to review the policy w The Licensee called conference and stated-They mailed a check money to his PayeeShe would fax over a -Not aware during the A text from the License 6:31pm revealed: -"Please confirm you document I sent. [Pame one time on 4/21/2 she called. I find out everyone tries to lie. proofs in order for wh will be to produce the not right. Thanks." Review on 5/12/2021 licensee revealed: -A copy of a check da	may be the payee, family Should it be determined met the financial eligibility 0 days, then a 30 day notice I be issued. to make sure the above or will assemble the meeting ithin the next 24 hours." on 5/11/2021 after the exit d: on 5/10/2021 of FC #7's a copy of the check. e exit it had been mailed. see on 5/11/2021 received at received all 15 pages yee representative] called 21. That was the only time that when state comes I hope they all have their en the time comes that they m. They are lying and that's	V 512			
	PayeeA correspondence from 12/1/20, " You need increase FBR amount SSI is suspended.) -A correspondence from 12/1/20, " You need increase FBR amount SSI is suspended.)	om the SA worker dated to go to Social Security and t for SSI (It shows that his om the SA worker dated to go to Social Security				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED				
						С				
MHL092-878		MHL092-878	B. WING			05/12/2021				
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE						
201 RAND MILL ROAD										
ABSOLUTE HOME #5 GARNER, NC 27529										
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETE				
V 512	Continued From page 12		V 512							
	-A correspondence letter dated 12/18/2020 to the payee representative revealed she needed assistance to get FC #7's SA approved and if he does not get approved, "We will not be able to continue to keep [FC #7]" -A correspondence between the Licensee and the Payee representative dated 2/4/21 regarding paperwork to SSI and possible discharge if not approved for SA.									
	admitted from the hose facility and was disch him giving notice. Not completed by FC #7 #7 had a designated money who received The Licensee admitted not receiving SA at the his monthly SSI benestay, the Licensee att was denied. The Licensee att was denied. The Licensee responsible for the romonth regardless if some The Licensee stated her as his payee, the have been resolved and now he owed based and now he owed ba	is of schizophrenia was spital on 10/20/20 to the arged on 2/23/2021 due to admission paperwork was who is his own guardian. FC payee agency to manage his his monthly SSI benefits. At FC #7 knowing he was at time and without knowing fit. Throughout FC #7's tempted to receive SA, but ensee stated FC #7 was om and board of \$1182.00 a the ever received his SA. If he would have designated process of getting SA would not therefore it was his fault tok pay for his room and to be determined what the ring October and November id receive a total of the spayee for December 2020 for his room and board. FC of in January 2021 which the ed was a stimulus check, but of know where the money nsee could not provide a C #7 had \$404.00 remaining								
	came from. The Lice copy of this check. F from his stimulus che	nsee could not provide a								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
AND I DAN OF CONNECTION			A. BUILDING:									
		MHL092-878	B. WING		C 05/12/2021							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
ABSOLUTE HOME #5 GARNER, NC 27529												
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE						
V 512	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 512									

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