STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL092-755		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		B. WING			R <b>02/23/2022</b>			
	PROVIDER OR SUPPLIER	MUNITY SERVICE	5628 MIL	DDRESS, CITY, STATE, ZIP CODE  LRACE RD  H, NC 27606				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 000	An annual and Follo 2/23/22. Deficiencies This facility is licens category 10A NCAO Living for Adults with	ow Up Survey was cles were cited. sed for the following C 27G .5600A Super	service vised	V 000				
V 114	AND SUPPLIES  (a) A written fire platarea-wide disaster shall be approved be authority.  (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions the	207 EMERGENCY Part for each facility are plan shall be develooy the appropriate lose made available to cedures and routes	PLANS  nd ped and cal  all staff shall be facility I be onducted rgencies.	V 114				
	failed to ensure fire conducted quarterly are:	view and interview to and disaster drills w y for each shift. The of Fire and Disaster	vere findings					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		l ,	R		
		MHL092-755		B. WING			23/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABSOLU	ITE HOME AND COMI	MUNITY SERVICE		LRACE RD , NC 27606			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1		V 114			
	-Fire Drill completed on 8/20/21 at 11:15 AMNo other drills present in the log.						
	monthsWorked two weeks -Had only complete did not write it dowr -Completed a Disas did not write it dowr Interview on 2/17/2 stated: -She had not been Drills like she shoul -Had told staff to co been checking behi doneThe notebook is pr document the drills	oloyed in the home for son and two weeks and one fire drill last with the profession of the Qualified Profession of the Qualified Profession of the Qualified Profession of the profession of th	off. eek but s ago and essional Disaster d not ney were or staff to				
V 118	27G .0209 (C) Medication Requirements		V 118				
	only be administered order of a person andrugs.  (2) Medications shad clients only when and client's physician.  (3) Medications, income.		vritten prescribe ed by y the all be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		D.   ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-755	B. WING			R <b>23/2022</b>
NAME OF	PROVIDER OR SUPPLIER		REET ADDRESS, CITY,	STATE, ZIP CODE	1	
ABSOLU	JTE HOME AND COM	MUNITY SERVICE	628 MILLRACE RD ALEIGH, NC 27606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	ID L PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ac all drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	s trained by a registered regally qualified person e and administer medic dministration Record (Mared to each client must les administered shall be ely after administration.	and ations. AR) of oe kept The g; and the or MAR			
	failed to ensure one medications were a	et as evidenced by: view and interview the f e of three clients (#3) administered on the writt n. The findings are:				
	-Admission date of -Diagnoses of Disru Disorder, Conduct	of client #3's record rev 4/2/21 uptive Impulse Control Disorder and Borderline omentally Disability (IDD				
	revealed:	of client #3's Physician n 10 mg- one at bedtime				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL092-755		B. WING			R <b>02/23/2022</b>		
ABSOLUTE HOME AND COMMUNITY SERVICE 5628 MILL				DRESS, CITY, S LRACE RD , NC 27606	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	-3/24/21-Vitamin D3 -3/24/21-Depakote -3/24/21-Lithium Ca Review on 2/17/22 revealed: -None of the above the facility.  Review on 2/17/22 Record (MAR) reve -The above medica administered daily.  During interview on -Client #3 just ran of dayWas out of Depako as he took his last p -Called in refills five -Medications were to Interview on 2/17/22 stated: -Medications are us 16th or 17th of the p -Was not aware client	3- one time a day 500 mg- twice a day arbonate 300 mg- twice of client #3's medicat medications were pr of Medication Admins aled: tions were initialed as 2/17/22 staff #1 state out of medications in the ote and Lithium this no ills last night. It days ago. It do be delivered today. It to be delivered today. It to be qualified Profese sually delivered arour	esent in estration estrati	V 118			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe	ty and Grounds Main  03 LOCATION AND  REMENTS  I its grounds shall be e, clean, attractive ar e kept free from offer	nd orderly	V 736			

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BOILDING.		R	
		MHL092-755	B. WING			23/2022	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE			
ABSOLU	JTE HOME AND COM	MIINITY SERVICE	MILLRACE RD GH, NC 27606				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From pa	ige 4	V 736				
	This Rule is not me Based on observatifailed to maintain the and safe manner.  Observation on 2/1 -The floor was dirty and grassClient #6 and #3's around rim and insimas covered in blace-Broken blinds in Colient #5 had his not another area of the Couch in client #5'. Baseboards through and dirt on themKitchen sliding doce-Walls through the Interview on 2/17/2 stated: -Some repairs had in the last few montain the last few montains.  [This deficiency has	et as evidenced by: ion and interviews the facility ine facility in a clean, attractive The findings are:  7/22 of the home revealed: through out the home with of bathroom toilet was black ide with feces. The shower ck mildew. lient #6 and #3's bedroom. nattress moved from his roo he home on the floor. s room was missing cushing gh our the home had thick d or was difficult to open. home were stained and dirty 2 Qualified Professional been completed in the home	e dirt m gs. ust				

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