Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C **03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD** **GARNER, NC 27529**

(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 A limited follow up and complaint survey was completed on 3/17/22. The complaint was substantiated (intake #NC00184860). The complaint was unsubstantiated (intake #NC00186964). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
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	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement strategies to meet the needs for 1 of 3 audited clients (#4). The findings are: Review on 2/25/22 of client #4's record revealed: - date of admission: 9/30/2021 - diagnoses of: Borderline Personality Disorder, Bipolar Disorder with psychotic features, Post Traumatic Stress Disorder, and Cannabis use - no treatment plan in the client's record Interview on 2/25/22 the QP reported: - client #4's treatment plan was located in the office. - she would bring the treatment plan to the facility. Interview on 2/25/22 the HM reported: - his job duties included: medication administration and ensuring clients were following their goals. Review on 3/17/22 of client #4's treatment plan dated 10/23/21 and presented on 3/17/22 revealed: - no goals to address unwarranted and excessive calls to 911.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C **03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 112	Continued From page 2 Review on 3/17/22 of a police call service log from the police department revealed: - between October 2021 & March 2021 the police had been to the facility 14 times in response to 911 calls from client #4. - calls were due to: client #4 had an emotional crisis, or verbal disagreements with housemates. Interview on 3/17/22 the Qualified Professional (QP) reported: - she was unaware of the number of calls made to 911 since September 2021. - she was responsible for updating the treatment plan. - she thought the treatment plan had been updated to reflect client #4's frequent calls to 911. - she admitted after reviewing the treatment plan, that it had not been updated to address client #4's frequent calls to 911. During interview on 3/17/22 the Administrator reported: - the QP was responsible for updating client #4's treatment plan. - she was not aware of the number of 911 calls made by client #4. - the QP would revise the plan to include interventions to address the frequent calls to 911 by client #4.	V 112		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion.	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 119	Continued From page 3	V 119		

(2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.
(3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.
(4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to dispose of 3 of 3 audited clients' (#1, #2,#4's) medications to guard against diversion or accidental ingestion.
The findings are:

Review on 3/3/22 of client #1's record revealed:
- admitted 12/24/15
- diagnoses of: Diabetes mellitus, Gastroesophageal Reflux Disease (GERD), Allergic Rhinitis, Hyperlipidemia, Hypertension (HTN), Schizophrenia, Bipolar Mood disorder,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 119	Continued From page 4	V 119		

delusional/paranoid type, Vitamin D deficiency, Bronchitis and Low back pain

Review on 3/3/22 of client #2's record revealed:
- admitted 6/19/14
- diagnoses of: Type 2 Diabetes, Schizophrenia and Hyperlipidemia

Review on 3/3/22 of client #4's record revealed:
- admitted 9/21
- diagnoses of: Borderline Personality Disorder, Bipolar disorder with psychotic features, Post Traumatic Stress Disorder (PTSD) and Cannabis use.

Observation on 2/25/22 between 1:30pm - 2:10pm of the House Manager's (HM) bedroom revealed 3 shopping bags with medications inside them.

Record Review on 3/4/22 of the Pharmacy Log revealed the following medications were collected from the facility on 2/26/22:
Client #1's Medications:
- Metformin Hydrochloride (HCL) Extended Release (ER) 500 milligram (mg), (quantity of 470) (diabetes)
- Losartan Potassium (Cozaar) 25 mg (quantity of 26) (antihypertensive)
- Januvia 100 mg (quantity of 77) (diabetes)
- Simvastatin 80 mg (quantity of 132) cholesterol)

Client #2's Medications:
- Atorvastatin 40 mg, (quantity of 50) (cholesterol)
- Divalproex Sodium (SOD) delayed released (Dr) 500 mg (quantity of 89) (seizures),
- Amlodipine Besylate 5 mg (quantity of 55) (high blood pressure)

Client #4's Medications:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 119	Continued From page 5	V 119		

-Wellbutrin HCL extended release (XL) 150 mg (quantity of 108) (antidepressant)

Interview between 2/25/22 and 3/7/22 the HM reported:
- The file cabinet in the dining room where extra medications were kept had a broken lock, so he transferred all medications to his room until the pharmacy could pick up the medications.
- He locked the door to his room while the medications were inside his room.
- Clients were allowed to use the bathroom located through his room.
- He observed that no one had access to the bags of medication.
- No one told him to store the medications in his room.
- The Administrator and the Qualified Professional (QP) review client medications every week or every two weeks.
- During the last medication review (in February 2022) by the QP and the Administrator, he was told to call the pharmacy to pick up the "extra" medications.
- He had contacted the pharmacy 2/23/22 and medications were supposed to be picked on 2/25/22.
- The pharmacy later notified him the medications would be picked up on 2/26/22.
- The medications were only in his room for one day.

Interview on 2/25/22 the Pharmacist #1 reported:
- The facility contacted the pharmacy on 2/23/22 to request a medication pick up.
- The pharmacy was scheduled to pick up the medications on 2/26/22.

Interview between 3/3/22 and 3/7/22 the QP reported:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ____ B. WING ____	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 119 | V 119

Continued From page 6

- The HM told her on 2/25/22 there were three bags of medications in his bedroom.
- They take the expired or excess medications to the Police Department or to the County Human Services Office to dispose of.
- In the future, they planned to come to the facility weekly to ensure excess or expired medications were disposed of properly.

Interview on 3/7/22 the Pharmacist #2 reported:
- The pharmacy had picked up the medications on 2/26/22.

During interview on 3/7/22 the Administrator reported:
- The HM contacted her on 2/23/22 to inform her that the cabinet with the stored medications would not lock. The lock was broken.
- She purchased a new locking cabinet for medication storage.

V 132 | V 132

G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection

G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY
(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:
a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 132	Continued From page 7 care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to investigate an allegation of neglect and notify the Department within 5 working days for one of two staff (#1). The findings are: During interview on 3/17/22 client #4 reported: - staff #1 gave him & client #1 marijuana - this happened the second day staff #1	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 132	Continued From page 8 worked at the facility - he knocked on both their doors & they went on the porch - "they puff puff passed on the front porch" - he did not tell anyone in management During interview on 3/17/22 client #1 reported: - he had not smoked marijuana with client #4 or staff #1 During interview on 3/17/22 staff #1 reported: - started at the facility on 3/4/22 - he could not be sure why client #4 alleged he smoked marijuana with him and client #1 - thought client #4 was upset he was being discharged from the facility - the police was called last week for another incident that involved client #4 - while the police was at the facility, client #4 informed the police he (staff #1) smoked marijuana with him (client #4) - he (staff #1) contacted the Administrator and the Qualified Professional (QP) to make them aware of the allegations During interview on 3/17/22 the QP reported: - she was not aware of any allegations staff #1 smoked marijuana with any clients - would ensure an investigation was completed and Health Care Personnel Registry was notified During interview on 3/17/22 the Administrator reported: - she was not aware of allegations staff #1 smoked marijuana with any clients	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C **03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 366	Continued From page 9 RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ____ B. WING ____	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 366	Continued From page 10 (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ____ B. WING ____	R-C **03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 366	Continued From page 11	V 366		

(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to implement their written incident reporting policy. The findings are:

Review on 3/7/22 of the facility's incident reporting policy revealed:
- "...the administrator will follow up on any reported client incidents...incident report forms will be reviewed on an ongoing basis to note trends....staff employed by AHCS (Absolute Home Community Services/Licensee) will monitor, investigate and evaluate patient incidences..."

Refer to V367 regarding details of incidents that occurred at the facility
- 14 police calls to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 366	Continued From page 12 During interview on 3/3/22 the Qualified Professional (QP) reported: - the police came to the facility multiple times for client #4 - an investigation was not completed During interview on 3/7/22 & 3/17/22 the Administrator reported: - the QP completed the incident reports - she (Administrator) was responsible for the investigation & follow up on the incident reports	V 366		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C **03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 367	Continued From page 13	V 367		

(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.
(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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 367	Continued From page 14 (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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report all level II incidents to the Managed Care Organization/Local Management Entity (MCO/LME) within 72 hours. The findings are: Review on 2/25/22 of the Incident Response Improvement System (IRIS) revealed no level II incident reports Review on 3/3/22 of client #4's record revealed: - admitted September 2021 - diagnoses of Borderline Personality Disorder, Bipolar Disorder with psychotic features & Post Traumatic Stress Disorder	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 367	Continued From page 15 Review on 3/17/22 of the local police call log revealed: - between October 2021 & March 2021 the police had been to the facility approximately 14 times - calls were due to: client #4's emotional crisis or verbal disagreement between client #4 & housemates During interview on 3/17/22 client #4 reported: - he called the police last week for a verbal incident with him and client #3 - sometimes he called mobile crisis due to an emotional crisis and the police would come During interview on 2/25/22 the House Manager (HM) reported: - client #4 had called the police on at least 3 different occasions - one time he went into an emotional crisis after a visit from his mom - another time he became upset because the staff did not open the freezer for him - he called the police because staff knocked on his door and he got upset - the Qualified Professional (QP) was aware of the incidents During interview on 3/3/22 & 3/17/22 the QP reported: - police had been to the facility multiple times for client #4 - there were no reason incident reports had not been completed During interview on 3/7/22 the Administrator reported: - client #4 called the police for "no reasons" - the QP was responsible for the completion of incident reports	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ______ B. WING ______	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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	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 was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 2/25/22 between 1:30 pm -2:30 pm during the facility tour revealed: - Four cracked tiles in between the threshold of the dining room and the laundry room. - Stove had streaks of spilled food down the front. - Three cracked floor tiles in the dining room by the table - Broken window blind in client #2's bedroom. - Hall bathroom had strong odor of urine - Hall bathroom door did not latch completely closed. - Broken vanity door under sink in hall bathroom. - Rust covered the entire metal air vent in the floor of the hall bathroom. - Golf ball size area of the wall near the hall bathroom window with peeled paint. - 12 inches of the wall beside the hall vanity bathroom with bubbled and peeled paint. - Client #4's door did not open and close smoothly. The door stuck and force must be	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: ___ B. WING ___	R-C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	**201 RAND MILL ROAD GARNER, NC 27529**

(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 17 applied to open or close completely. - Client #1's bedroom had a broken window pane. - Hall air return covered in rust. - Paint peeling the size of a tennis ball on the door facing of the door way to the kitchen. - Client #1 and Client #4 were missing sheets for their beds. Interview on 3/7/22 the Administrator reported: - She comes to the facility once a week and observed the client rooms. - "We are always doing repairs." - Two years ago they painted the inside of the home. - She was not aware that there were any issues with the paint peeling. - "We repaired some things in the shower and repaired bathroom cabinet. Touch up painted some of the back wall in the kitchen." - They planned to replace or re-tile the floors.	V 736		