	FOF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOWBER.	A. BUILDING: _		
		MHL032-611	B. WING		R 03/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ABSOLUT	E HOME-ROXBORO ST	REET	TH ROXBORO NC 27707	STREET	
(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 APPROPE DEFICIENCY)	BE COMPLETE
V 000	/ 000 INITIAL COMMENTS		V 000		
	An annual and follow- on March 30, 2022. D	up survey was completed eficiencies cited.			
	category: 10A NCAC	d for the following service 27G. 5600A Adults with Mental Illness			
	The survey sample co				
V 114	27G .0207 Emergeno	y Plans and Supplies	V 114		
	AND SUPPLIES (a) A written fire plan area-wide disaster plashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and the appropriate local made available to all staff dures and routes shall be drills in a 24-hour facility			
	failed to conduct fire a shift at least quarterly Review on 3/29/22 of disaster drills record r	ew and interviews the facility and disaster drills on each . The findings are: the facility's fire and			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
			_			R
		MHL032-611	B. WING		03	/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, STATE	E, ZIP CODE		
ABSOLUT	TE HOME-ROXBORO ST	2826 SO	UTH ROXBORO S	TREET		
		DURHAN	I, NC 27707			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From page	e 1	V 114			
	shift from September Interview on 3/29/22 -She was the live-in s -She only conducted and 2nd shiftConfirmed she did n drills on 3rd shift. Interview on 3/30/22 Professional revealed -Confirmed staff #1 d disaster drills on 3rd suffice.	ter drills conducted on 3rd 2021 - March 2022. with Staff #1 revealed: staff. fire and disaster drills on 1st ot conduct fire and disaster with the Qualified				
V 118	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, incluadministered only by unlicensed persons to pharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered	9 MEDICATION	V 118			

Division of Health Service Regulation

STATE FORM 6899 3GNT11 If continuation sheet 2 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL032-611	B. WING		R 03/30/2022
	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATH ROXBORO NC 27707		,
(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 APPROPE DEFICIENCY)	BE COMPLETE
V 118	MAR is to include the (A) client's name; (B) name, strength, at (C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record	r after administration. The following: nd quantity of the drug;	V 118		
	failed to have physicia medications affecting (#3). The findings are Review on 3/29/22 of - Admission date of 5, - Diagnosis of Schizo Type, Major Depressi and Diabetic Physician order date -True Metrix Test week on Monday, We Review on 3/29/22 of Administration Record revealed:	ew and interviews the facility an orders to administer one of three audited clients e: Client #3 record revealed: /13/21. affective Disorder, Bipolar ve Disorder, Single Episode ed 6/9/21 revealed: Strips - Test 3 times per ednesday and Friday. Client #3's Medication d from January-March 2022			

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STATE FORM 6899 3GNT11 If continuation sheet 3 of 13

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL032-611	B. WING		R 03/3	0/2022
	ROVIDER OR SUPPLIER	2826 SOUT	RESS, CITY, STA H ROXBORO NC 27707	•	,	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	medication revealed to True Metrix Test Stripted Glucose Monitoring Metrix Test Stripted Glucose Monitoring Metrix Test Stripted Glucose Monitoring Metrix Monitoring Metrix Monitoring Metrix Monitoring Metrix Monitoring Monitoring Metrix Monitoring Monitoring Metrix Monitoring Monitoring Metrix Metrix Monitoring Metrix Metrix Monitoring Metrix Metrix Monitoring Metrix Metrix Monitoring Metrix Monitoring Metrix Monitoring Metrix Monitoring Metrix Monitoring Metrix Monitoring Metrix Metrix Monitoring Metrix	22 at 9:30 a.m. of Client #3's he following available: 0s. Kit. with Staff #1 revealed: ed his own blood sugar week. ed blood sugar checks and s on document. with the Qualified : 3 self-administered blood 3 had a self-administered dministered order was not in or's appointment next week self-administered order. HCPR - Prior Employment LTH CARE PERSONNEL alth care personnel into a service, every employer at a sell access the Health Care and shall note each incident	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
			P WING	B. WING	
		MHL032-611	B. WING		03/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ABSOLUT	E HOME-ROXBORO ST	REET	TH ROXBORO	STREET	
	Г	<u> </u>	NC 27707		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 131	Continued From page	e 4	V 131		
	failed to access the H Registry (HCPR) prio two audited staff (#1)	ew and interview the facility lealth Care Personnel r to employment for one of			
	revealed:	otali #13 personner record			
	-Hired date: 9/15/21. -Live-In Paraprofession	onal			
	-HCPR check was ac				
	-There was no evider	nce the HCPR check was			
	accessed prior to emp	ployment.			
	Interview on 3/30/22 v	with the Qualified			
	Professional revealed				
		as responsible for accessing			
	HCPR for staff #1 prid	or to employment. HCPR was not accessed			
	prior to employment.	nork was not accessed			
	pe. to eproye.				
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133		
	CHECK REQUIRED APPLICANTS FOR E				
	l	an area authority/county			
		vider of mental health, lity, and substance abuse			
	•	able under Article 2 of this			
	Chapter.	n offer of employment by a			
	provider licensed und				
	applicant to fill a posit	tion that does not require the			
		occupational license is			
		nt to a State and national disches of the applicant. If			
	_	n a resident of this State for			

Division of Health Service Regulation

STATE FORM 6899 3GNT11 If continuation sheet 5 of 13

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Division of	of Health Service Regu	lation			
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		MHL032-611	B. WING		03/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE	
		2826 SOI	JTH ROXBORO		
ABSOLUT	E HOME-ROXBORO ST	REET	I, NC 27707		
(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 APPROPE DEFICIENCY)	BE COMPLETE
V 133	Continued From page	÷5	V 133		
	criminal history record national criminal histo include a check of the the applicant has bee	sent to a State and national dicheck of the applicant. The bry record check shall applicant's fingerprints. If n a resident of this State for en the offer is conditioned			
	on consent to a State check of the applican employ an applicant v	criminal history record			
	section. Except as oth subsection, within five the conditional offer of	nerwise provided in this e business days of making f employment, a provider t to the Department of			
	Justice under G.S. 11 criminal history record	•			
	check required by this	ate criminal history record s section. Notwithstanding pepartment of Justice shall			
		ational criminal history ployment positions not w 105-277 to the			
	Department of Health Criminal Records Che	and Human Services, eck Unit. Within five			
	history of the person, and Human Services,	eipt of the national criminal the Department of Health Criminal Records Check			
	information received of the applicant. In no	rovider as to whether the may affect the employability case shall the results of the			
		ry record check be shared viders shall make available			

Division of Health Service Regulation

upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank

STATE FORM 6899 3GNT11 If continuation sheet 6 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		
		MHL032-611	B. WING		R 03/30/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓΕ, ZIP CODE	
		2826 SO	UTH ROXBORO	STREET	
ABSOLUTE HOME-ROXBORO STREET			M, NC 27707		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 133	133 Continued From page 6		V 133		
	may conduct on behaciminal history record section without the prequest to the Depart case, the county shall criminal history record section within five bus conditional offer of en All criminal history information provider is confidential except to the applican (c) of this section. For subsection, the term business regularly en criminal history record records obtained from (c) Action If an applied record check reveals a relevant offense, the of the following factor hire the applicant: (1) The level and seri (2) The date of the criminal commission of the criminal form (5) The nexus between the person and the join filled. (6) The prison, jail, prison	alf of a provider a State d check required by this rovider having to submit a ment of Justice. In such a l commence with the State d check required by this siness days of the apployment by the provider. Formation received by the all and may not be disclosed, and the approvided in subsection are purposes of this private entity means a gaged in conducting dischecks utilizing public in a State agency. Ilicant's criminal history one or more convictions of the provider shall consider all is in determining whether to cousness of the crime. The surrounding the me, if known. The the criminal conduct of the duties of the position to be cobation, parole,			
	person since the date (7) The subsequent of a relevant offense. The fact of conviction shall not be a bar to elisted factors shall be	the crime was committed. The crime was committ			

Division of Health Service Regulation

STATE FORM 6899 3GNT11 If continuation sheet 7 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL032-611	B. WING		0.2	R	
	WITE032-611			03	/30/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE			
ABSOLUTE HOME-ROXBORO ST	REET 2826 SOI	JTH ROXBORO ST	REET			
ABSOLUTE HOME-ROXBORO ST	DURHAN	I, NC 27707				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 133 Continued From pag	e 7	V 133				
consideration of the provider may disclos the criminal history reto the disqualification of the criminal history applicant. (d) Limited Immunity or employee of a procomplies with this secivil liability for: (1) The failure of the individual on the bas the criminal history re(2) Failure to check a criminal offenses if thistory record check compliance with this (e) Relevant Offense "relevant offense" me federal criminal history indictment of a crime felony, that bears uphave responsibility for persons needing medisabilities, or substactimes include the crany of the following A General Statutes: Ar Issuing Monetary Su Endangering Execution Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdulnjury or Damage by Incendiary Device or	relevant factors, then the e information contained in ecord check that is relevant a, but may not provide a copy of record check to the an ecord check to the an ecord check to the an ecord check to the an exployer record check of the individual. In employee's history of the employee's criminal is requested and received in section. The an exployee's criminal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's criminal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's criminal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's remainal is requested and received in section. The an exployee's remainal is requested and received in section. The exployee's criminal is requested and received in section. The exployee's criminal is requested and received in section. The exployee's criminal is requested in section. The exployee's criminal is requested in section. The exployee's criminal is requested in section. The exployee's history of the individual is requested in section. The explosive of the individual is fitness to or the safety and well-being of the explosion of the section. The explosion is relevant to the explosion of the explos	V 133				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MHL032-611	B. WING		R 03/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			UTH ROXBORO		
ABSOLUT	E HOME-ROXBORO STI	REET	I, NC 27707		
0/10/15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 133	Continued From page	e 8	V 133		
	Ohtaining Property or	Services by False or			
		edit Device or Other Means;			
		Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against				
	_	, Adult Establishments;			
	1	n; Article 28, Perjury; Article			
	29, Bribery; Article 31	, Misconduct in Public			
	Office; Article 35, Offe	enses Against the Public			
		liots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam				
		cle 60, Computer-Related			
		also include possession or			
	_	ion of the North Carolina			
		es Act, Article 5 of Chapter atutes, and alcohol-related			
		e to underage persons in			
	violation of G.S. 18B-	• .			
		of G.S. 20-138.1 through			
	G.S. 20-138.5.	51 0.0. 20 100.1 amough			
		ning False Information Any			
		nent who willfully furnishes,			
		e gives false information on			
		cation that is the basis for a			
		d check under this section			
		ass A1 misdemeanor.			
		yment A provider may			
	employ an applicant				
	_	of a criminal history record			
		applicant if both of the			
	following requirement				
		not employ an applicant			
		applicant's consent for d check as required in			
	_	section or the completed			
		equired in G.S. 114-19.10.			
		submit the request for a			
		d check not later than five			

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STATE FORM 6899 3GNT11 If continuation sheet 9 of 13

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL032-611	B. WING		0:	R 3/30/2022
	ROVIDER OR SUPPLIER	2826 SC	ADDRESS, CITY, STATE OUTH ROXBORO ST	,		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 133	business days after the conditional employmed 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4, and the conditional offer of audited staff (#1). The Review on 3/30/22 of revealed: -Hired date: 9/15/21. -Live-In Paraprofessising-The criminal record of the Interview on 3/30/22. Professional revealed: -The Administrator was State criminal record five business days of of employment.	ne individual begins ent. (2000-154, s. 4; .124, ss. 10.19D(c), (h); .5(a); 2007-444, s. 3.) as evidenced by: ew and interview, the facility tate criminal record check we business days of making of employment for one of two ne findings are: Staff #1's personnel record onal. check was ordered 11/3/21.	V 133			
V 736	ordered after the con	ditional offer of employment. and Grounds Maintenance	V 736			
		EMENTS				

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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	A. BUILDING:		
		MHL032-611	B. WING		R 03/30/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ABSOLUT	E HOME-ROXBORO STI	REET	TH ROXBORO	STREET		
		DURHAM	NC 27707			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	ETE.
V 736	Continued From page	e 10	V 736			
	odor.					
	This Rule is not met					
	Based on observation failed to ensure the fa	n and interview, the facility				
	maintained in a safe,					
	manner. The findings					
		22 at 11:30 a.m. revealed: had a large hole in the wall.				
		e was broken and off track.				
		was leaning on one side and				
	deflated.	. 4. 46				
	was broken.	to the right dresser draw				
	Interview on 3/30/22	with the Qualified				
	Professional revealed					
	-She confirmed the id					
	the wall fixed and pur	vith the Administrator to get				
	and mail invoca and par	onace new rannare.				
	•	itutes a re-cited deficiency				
	and must be correcte	d within 30 days.				
V 752	27G .0304(b)(4) Hot	Water Temperatures	V 752			
		4 FACILITY DESIGN AND				
	EQUIPMENT	litu alaali ka alaais:				
		lity shall be designed, pped in a manner that				
		safety of clients, staff and				
	visitors.					
		the facility where clients are				
	exposed to hot water	, the temperature of the				

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STATE FORM SGNT11 If continuation sheet 11 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			74. BOILDING			R
		MHL032-611	B. WING		03	3/30/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ARSOLUT	TE HOME-ROXBORO ST	2826 SO	UTH ROXBORO S	TREET		
ABSULUI	IE HOME-ROXBORO ST	DURHAN	M, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	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 752	Continued From page	e 11	V 752			
	water shall be mainta degrees Fahrenheit.	ained between 100-116				
	failed to ensure the v	as evidenced by: n and interviews the facility vater temperatures were 100-116 degrees Fahrenheit.				
	11:50am revealed: -Kitchen -129 de -Two bathrooms -Water tank did i water temperature. -Bathroom sink l	egrees Fahrenheit - 125 degrees Fahrenheit not allow ability to adjust had one faucet handle and knob to adjust water				
	revealed: -There had no compl being too hotThey liked the water outside.					
	Client #3 was unavai temperature check.	lable during the water				
	-She was the live-in s -No client reported po from the bathroom si	roblems with the hot water				

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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	
					R	
		MHL032-611	B. WING		03/30/2022	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ABSOLUT	TE HOME-ROXBORO STR	REET	TH ROXBORO , NC 27707	STREET		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	Ξ
V 752	preparationShe reported clients report problems with the state of t	that prepared meals did not the hot water. th the hot water in the with the Qualified	V 752			

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