Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
						R		
		MHL092-960	B. WING		10/24	/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
ABSOLI	ABSOLUTE CARE HUMAN SERVICES 3905 IVERSON STREET							
ADOOLO	TE GARL HOMAN GE	RALEIGH	, NC 27604					
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE			
{V 000}	INITIAL COMMENT	-S	{V 000}					
	was completed on a follow up survey, o Facility Design and compliance. The focompliance 10A NO Design and Equipm cited.	survey for the Type A2 survey 10/24/22. This was a limited nly 10A NCAC 27G .0304 Equipment was reviewed for ollowing was brought back into CAC 27G .0304 Facility tent. No deficiencies were seed for six and has a current survey sample consisted of ent clients.						
{V 113}	27G .0206 Client R	ecords	{V 113}					
	(a) A client record sindividual admitted contain, but need not (1) an identification (A) name (last, first (B) client record nut (C) date of birth; (D) race, gender and (E) admission date; (F) discharge date; (2) documentation of developmental disa diagnosis coded ac (3) documentation of assessment; (4) treatment/habilit (5) emergency infor shall include the nanumber of the personant telephone numphysician;	face sheet which includes: , middle, maiden); mber; d marital status; of mental illness, bilities or substance abuse						

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

TITLE (X6) DATE

	<u>of Health Service Re</u>					T	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	SUPPLIER/CLIA FION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
, L L L L L L L L L L L L L L L L L	5. 5014 E011014	ISERTII IOA		A. BUILDING:			
				B. WING		1	₹
		MHL092	-960	D. WING		10/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABSOLU	TE CARE HUMAN SE	RVICES		RSON STREE , NC 27604	ET .		
()(A) ID	CLIMMA DV CTA	TEMENT OF DEFI			PROVIDER'S PLAN OF CORRECTI	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{V 113}	Continued From pa	ge 1		{V 113}			
	responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.						
	This Rule is not me	et as evidence	d by:				
{V 114}	27G .0207 Emerge	ncy Plans and	Supplies	{V 114}			
	10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaster shall be held at lease	in for each faci plan shall be do by the appropri e made availa cedures and ro /.	ility and leveloped and ate local ble to all staff outes shall be hour facility				

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STATE FORM 6899 If continuation sheet 2 of 6 5DTH12

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		R		
		MHL092-960	B. WING			4/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ABSOLU	TE CARE HUMAN SE	RVICES	RSON STREE , NC 27604	ΞΤ		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
{V 114}	Continued From pa	ge 2	{V 114}			
	under conditions th	shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				
	This Rule is not me	et as evidenced by:				
{V 289}	27G .5601 Supervis	sed Living - Scope	{V 289}			
	provides residential home environment these services is the rehabilitation of individuals, a developm or a substance abusupervision when ir (b) A supervised like the facility serves e (1) one or mode (2) two or mode (3) two or mode (3) two or mode (3) two or mode (4) tw	ng is a 24-hour facility which a services to individuals in a where the primary purpose of e care, habilitation or ividuals who have a mental ental disability or disabilities, se disorder, and who require in the residence.				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		MHL092-960	B. WING		F 10/2	R 24/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ABSOLU	ITE CARE HUMAN SE	RVICES	RSON STREE , NC 27604	ET .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{V 289}	developmental disadiagnoses; (4) "D" designoses; (4) "B" designoses; (5) "E" designoses; (5) "E" designoses; (6) "F" designoses; (6) "F" designoses; (7) Three adult clients who is a substance abuse done other diagnoses; (8) "F" designoses; (9) "F" designoses; (10) "F" designoses; (11) designoses; (12) designoses; (21) designoses; (22) designoses; (32) designoses; (4) "F" designoses; (5) "F" designoses; (6) "F" designoses; (7) designoses; (8) "F" designoses; (9) retreated to the diagnoses; (10) "F" designoses; (11) designoses; (11) designoses; (12) designoses; (13) designoses; (14) "D" designoses; (16) "E" designoses; (16) "F" designoses; (16) "F" designoses; (16) "F" designoses; (17) designoses; (18) designoses	e primary diagnosis is a ability but may also have other nation means a facility which se primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor ary diagnoses is abilities but may also have no live with a family and the service. This facility shall be llowing rules: 10A NCAC 27G (4),(5)(A)&(B); (6); (7) H); (8); (11); (13); (15); (16); CAC 27G .0202(a),(d),(g)(1) .0203; 10A NCAC 27G .0205 27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e) ard 10A NCAC 27G .0304 acility shall also be known as ving or assisted family living	{V 289}			
	This Rule is not me	et as evidenced by:				

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5DTH12

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	or riealth Service IN		T		T			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
					F	₹		
		MHL092-960	B. WING		1	4/2022		
					1 10/2			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
ABSOLU	ABSOLUTE CARE HUMAN SERVICES 3905 IVERSON STREET							
		RALEIGH	I, NC 27604					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)		
PRÉFIX	•	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE		
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FRIATE	DAIL		
{V 290}	27G .5602 Supervis	sed Living - Staff	{V 290}					
	10A NCAC 27G .56							
		os above the minimum						
		in Paragraphs (b), (c) and (d)						
		e determined by the facility to						
		ond to individualized client						
	needs.							
	\ <i>\</i>	one staff member shall be						
		when any adult client is on the						
		hen the client's treatment or						
		cuments that the client is						
		ng in the home or community						
		. The plan shall be reviewed						
		ess than annually to ensure						
		to be capable of remaining in						
		unity without supervision for						
	specified periods of							
		resent in a facility in the						
		f ratios when more than one						
	child or adolescent							
	\ /	or adolescents with substance						
		all be served with a minimum						
		for every five or fewer minor						
	•	owever, only one staff need be						
		ping hours if specified by the						
		p procedures determined by						
	the governing body	, or or adolescents with						
	\ /							
		bilities shall be served with						
		or every one to three clients off present for every four or						
		nt. However, only one staff						
		iring sleeping hours if						
		lergency back-up procedures						
	determined by the							
		ch serve clients whose primary						
		nce abuse dependency:						
		ne staff member who is on						
		d in alcohol and other drug						
		ns and symptoms of						

6899

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3905 IVERSON STREET	2022
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	2022
ABSOLUTE CARE HUMAN SERVICES RALEIGH, NC 27604	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(V 290)  Continued From page 5 secondary complications to alcohol and other drug addiction, and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.  This Rule is not met as evidenced by:	

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