	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			C
		MHL092-836	B. WING			16/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BSOLU	TE HOME AND COM	MUNITY SERVICE	MANDY STRE C 27511	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	ſS	V 000	DEHOLING	• ,	
	A complaint survey The complaint was	was completed on 5/16/23. substantiated (Intakes # 51 & 00201957). Deficencies				
		sed for the following service C 27G .5600A Supervised h Mental Illness				
	has a census of six	sed for six clients and currently . The survey sample of three current clients.	/			
V 115	27G .0208 Client S	ervices	V 115			
	 (a) Facilities that prassure that: (1) space and super the safety and welfa (2) activities are suitand treatment/habit served; and (3) clients participation activities. (h) Facilities or proging these Rules as "2 available 24 hours are unless otherwise spice) Facilities that see clients shall ensure (d) When clients what are transported, the with secure adaptive (e) When two or more require special assisted assisted assisted as a secure adaptive (e) when two or more present assisted as a secure adaptive assisted as a secure adaptive assisted as a secure adaptive as a	itable for the ages, interests, itation needs of the clients te in planning or determining grams designated or described 24-hour" shall make services a day, every day in the year. Decified in the rule. Erve or prepare meals for that the meals are nutritious. The have a physical handicap e vehicle shall be equipped the equipment. The preschool children who stance with boarding or riding				
	in a vehicle are trar	nsported in the same vehicle, adult, other than the driver, to				

PRINTED: 05/23/2023 FORM APPROVED

TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL092-836	B. WING			C 16/2023
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIP CODE		
		413 NOF				
BSOLU	TE HOME AND COM	MUNITY SERVICE CARY, N	C 27511			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
V 115	Continued From pa	age 1	V 115			
	This Rule is not m	et as evidenced by:				
	Based on observat	ion and interviews the facility				
		eals served were nutritious for				
	six of six clients. T	he findings are:				
		1/23 at 9:49 AM revealed:				
	 Refrigerator conta food. 	ined five containers of left over	-			
	-Half a pack of deli	style meat				
		hup, mustard, mayonnaise)				
	-Pitcher of water					
	-Bag of dried out ca					
	of oatmeal.	cans of vegetables and a box				
	Interview on 5/11/2					
	-Had not had break	5				
	-Did not have anyth	ning to eat. out no milk, eggs or waffles.				
		for a few weeks now.				
		breakfast because staff had				
	not made anything					
		e enough food in the home. bank at the church on				
	Saturdays to get fo					
		not bring enough food for				
		or others in the home with his				
	own money and the	e Licensee had never				
	reimbursed him for					
	-His boss brings fo brought food over.	od as well as client #2's mom				
tion of H	ealth Service Regulation					

STATE FORM

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		MHL092-836	B. WING			C 16/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ABSOLU	TE HOME AND COM	MUNITY SERVICE 413 NOR CARY, N	MANDY STRE C 27511	ET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 115	Continued From pa	ige 2	V 115			
	they only had frozer -The Licensee gave shop with every two -\$300.00 is not eno -Two clients have d healthy. Interview on 5/11/22 -Food is always low -Had not had break there was nothing t -Sleeps late someti breakfast. -Staff had not prepa morning. -Got a lot of food fro church. -Since they started food cards the Lice reduced. -Staff did not have to grocery store with th purchases. -They would have to someone to take th -His mom would bri month due to them -The Licensee knew bank. Interview on 5/11/22 -A diabetic who use	augh to feed six grown men. liabetes and they need to eat 3 client #2 stated: 7. If ast this morning because o eat. Imes and does not eat ared any breakfast this om the food bank at the going to the food bank, the nsee was giving the staff had transportation to go to the he food cards to make o wait until the Licensee sent rem grocery shopping. ing food over at the end of the running low. W they were going to the food 3 client #3 stated: ed insulin daily. I not eaten breakfast because t.				
		con, but did not eat pork. nce they had food in the				

Division of Health Service Regulation STATE FORM

6899

R2L411

If continuation sheet 3 of 11

	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE S COMPL	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	
		MHL092-836	B. WING		C 05/1	; 6/2023
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	TATE, ZIP CODE		
		413 NOR				
BSOLU	TE HOME AND COM	MUNITY SERVICE CARY, NO	_			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
V 115	Continued From pa	age 3	V 115			
	-They only get a litt there are six men i	le bit of groceries at a time and n the home.				
	Interview on 5/11/2	3 Staff #1 stated:				
		ome and clients can pick out				
	what they wanted to	o eat daily. breakfast this morning, they				
	can fix what they w					
) cards to local grocery store to				
	spend on food.					
		d cards by the Licensee.				
		portation to go get the food. Licensee to send someone to				
		by and get the grocery list.				
	-Got the \$300.00 e					
	-"There is food here	e to eat, they just don't want it."				
	Interview on 5/15/2	3 Client #2's mom stated:				
		a while now about the food in				
	the home.					
		/e healthy options to eat.				
	told her they did no	to the home because client #2				
		ne food bank on the weekends				
		e they did not have enough for				
	everyone.					
		e food donations they get, the				
	less the Licensee p	I planning and clients were left				
	to fix their own.	a planning and oliente were left				
	-Lots of frozen entr	ée style meals that were high				
	in sodium and carb					
		e have diabetes and need				
	healthy options. -Had not had the g	rocery cards for a few weeks				
	until last week.					
		transportation to get to the				
		ies when they did receive the				
	cards.	vovidor by bringing food but				
	ealth Service Regulation	provider by bringing food, but				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL092-836	B. WING			C 16/2023
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BSOLU	TE HOME AND COM	MUNITY SERVICE	RMANDY STRE	ET		
(X4) ID	SUMMARY STA		IC 27511	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 115	Continued From pa	ige 4	V 115			
	hated to see the cli	ents go without.				
	stated: -She had been to th noticed there was n -Called the License needed to run by an -Aware the clients h bank on the weeke -The Licensee told	had been going to the food	ł			
	-Went by the house -Gave staff \$300.00 twice a month. -If they ran out of for by. -Didn't send them to not aware of them g -If they went to the how much food she -Had checked the f cabinet last week a -Asked clients if the not. -Staff can send her picked up. -The staff is respon	food bank, that did not reduce e purchased for the home. ood in the refrigerator and ind it seemed fine. ey needed food and was told a list for items they want asible for food preparation. aff and not sure he knew to let				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	10A NCAC 27G .02 REQUIREMENTS	209 MEDICATION				
	(c) Medication adm					

STATEMEN	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		MHL092-836	B. WING		C 05/1	; 6/2023
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		413 NOF	MANDY STRE			
ABSOLU	TE HOME AND COM	CARY, N	C 27511			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	age 5	V 118			
	only be administered order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, ind administered only b unlicensed persons pharmacist or othe privileged to prepar (4) A Medication Ad all drugs administe current. Medication recorded immediat MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time t (E) name or initials drug. (5) Client requests checks shall be rec file followed up by a with a physician.	non-prescription drugs shall ed to a client on the written authorized by law to prescribe all be self-administered by puthorized in writing by the cluding injections, shall be by licensed persons, or by s trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) of red to each client must be kep administered shall be tely after administration. The the following: administering the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	Review on 5/12/23	of client #2's record revealed:				

Division of Health Service Regulation STATE FORM

R2L411

If continuation sheet 6 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		MHL092-836	B. WING			C 16/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ABSOLU	ITE HOME AND COM	MUNITY SERVICE 413 NOR CARY, N	MANDY STRE C 27511	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 6	V 118			
		10/17/18 lar Disorder-currently aumatic Stress Disorder &				
	-Bupropion Hcl 150 -Bupropion Hcl 300 -Olanzapine 2.4 mg -Lithium Carbonate -Propranolol 20 mg	mg- once a day g- once a day 450 mg- 2 at bedtime - twice a day I- two at 3 pm and 3 at				
	Further review on 5 revealed no physici	/12/23 of client #2's record an orders present.				
	state: -Not sure where clie located. -The Licensee usua made sure those or	ere are orders placed in their				
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	level II incidents, ex the provision of billa consumer is on the incidents and level to whom the provide	UIREMENTS FOR				

Division	of Health Service Re	egulation				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		MHL092-836	B. WING			C 16/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
			MANDY STRE	ET		
ABSULU	TE HOME AND COMI	CARY, N	C 27511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
V 367	Continued From pa	ge 7	V 367			
	responsible for the	catchment area where				
		ed within 72 hours of				
	0	the incident. The report shall				
		orm provided by the				
		ort may be submitted via mail, or encrypted electronic				
		shall include the following				
	information:					
	(1) reporting	provider contact and				
	identification inform					
	 (2) client identification information; (3) type of incident; 					
	(3) type of incident;(4) description of incident;					
	(4) description of incident,(5) status of the effort to determine the					
	cause of the incide					
		viduals or authorities notified				
	or responding.					
		B providers shall explain any				
		ete information. The provider lated report to all required				
		the end of the next business				
	day whenever:					
	•	ler has reason to believe that				
		d in the report may be				
		ing or otherwise unreliable; or				
		ler obtains information				
	unavailable.	dent form that was previously				
		B providers shall submit,				
		ELME, other information				
	obtained regarding	the incident, including:				
	• • •	ecords including confidential				
	information;	41				
		/ other authorities; and				
		ler's response to the incident. B providers shall send a copy	,			
		nt reports to the Division of				
		elopmental Disabilities and				
		Services within 72 hours of				

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		MHL092-836	B. WING			C 16/2023
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
Beolin	TE HOME AND COM	413 NOR	MANDY STRE			
		CARY, N	C 27511			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
V 367	Continued From pa	age 8	V 367			
	providers shall semincidents involving Health Service Reg becoming aware of client death within s or restraint, the pro- immediately, as red .0300 and 10A NC/ (e) Category A and report quarterly to t catchment area wh The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (3) searches (4) seizures of the possession of a (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the criti (a) and (d) of this F through (4) of this F	number of level II and level III rred; and ent indicating that there have i incidents whenever no urred during the quarter that teria as set forth in Paragraphs Rule and Subparagraphs (1)	t			
icion of Ho	ealth Service Regulation					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		MHL092-836	B. WING			C 16/2023
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BOUI		MUNITY SERVICE 413 NOF	RMANDY STRE	ET		
		CARY, N	IC 27511			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From pa	ige 9	V 367			
		evel sll incident report was of three (#1) clients. The				
	-Admission date of	of client #1's record revealed: 3/10/23 zophrenia and Diabetes Type				
	Touch Pen 100 unit	lated 2/17/23 for Levemir Flex ts, Inject 30 units at bedtime. -April 7, 2023 not initialed as				
	Improvement Syste	of the Incident Reporting em (IRIS) did not have a level l client #2's medication error.	I			
	stated: -Worked the week	3 with Former Staff (FS #1) of April 3-7 2023. f April 3-7 2023 she did not				
	-Could not find the administer the insu		0			
	-Not sure if she let know the client did	that the insulin was not given. the Qualified Professional not receive his insulin. cument missed medications.				
	stated:	3 The Qualified Professional 23 from local police				
	"welfare" check reg his insulin.	he had responded to a arding client #2 not receiving				
	had not administere last few days.	e and found out that FC #1 ed client #2's his insulin for the				
	-Client #2 was cheo Emergency Depart	cked and taken to the ment for follow up.				

Division of Healt STATE FORM

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL092-836	B. WING			C 16/2023
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
		413 NOR				
BSOLU	TE HOME AND COM		C 27511			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
V 367	Continued From pa	age 10	V 367			
		a level II incident report for				
	client #2 missing h	nis medication.				
		ekend and time got away from member to go back and				
	complete the Leve	el II.				
	-This was an overs	sight on her part.				