STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL092-946		B. WING		R-C 06/13/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
ABSOLU	ITE HOME - MARCON	Y WAY	CONY WAY , NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	on 6/13/24. The cor (Intake #NC002168 Deficiencies were co					
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
		sed for 6 and has a current irvey sample consisted of clients.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the					

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL092-9) 46	B. WING		I	l-C 13/2024
	PROVIDER OR SUPPLIER	IY WAY	3316 MAF	DRESS, CITY, S RCONY WAY , NC 27610	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 290			V 290				
	Hypertension, and - Admission Ass	4 ranoid Schizoph End Stage Rena essment dated 4 ve and monitor. eriods of time, d	renia, al Disease 4/4/24 stated: Do not leave				

Division of Health Service Regulation

STATE FORM 6899 E77Q11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		R-C		
		MHLO	92-946	B. WING			3/2024
NAME OF PROVIDER OR SUPPLIER STREET ADD				DRESS, CITY, S	STATE, ZIP CODE		
ABSOLUTE HO	ME - MARCON	IY WAY		CONY WAY , NC 27610			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
- U 12/23 - comm staff in be with individence of the constant	nunity with month the vicinity of thin audible and dual)." It do documentate of the vicinity of documentate of the vicinity of	cime assess out the neigoderate super of the individual raison of an uppassessment of a Risper ection was gurrently at the tation pickets of the Qualification only pack to the faced client #6 olic transportation was station was statio	hborhood or ervision requiring dual (i.e. staff must age of the evoluted by the evoluted evol	V 290			
10A N	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS		V 736				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.			R-C	
		MHL092-946	B. WING		I	-C 13/2024
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
ABSOLU	ITE HOME - MARCON	IY WAY	RCONY WAY , NC 27610			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 736	6 Continued From page 3		V 736			
	(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:					
	10:30am revealed - client #2's bedi missing slat	oom window blind had a				
	 client #6's bedroom window blind had a missing slat the bathroom commode upstairs had a crack in the molding on the top base of the commode client #4 & #5's bedroom had missing floor tiles near both their beds 					
	 the stairway had and downstairs in a seating are multiple water stair a white spot the floor tile in the downstairs a wooden bars had dirt across the an upholstered seating area had m 	ea downstairs, there were as on the ceiling e size of a basketball in the				
	wood across the end of the control o	ntire top portion of it 6/11/24 staff #1 reported: parstool was dirty but it still 6/13/24 the Qualified				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MUI 002 046				R-C 06/13/2024		
MHL092-946					06/1	3/2024	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S RCONY WAY	STATE, ZIP CODE			
ABSOLU	TE HOME - MARCON	IY WAY	NC 27610				
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 736	Continued From page 4		V 736				
	home but no update	e had been made					
	This deficiency has been cited 7 times since the original cite on 12/5/17 and must be corrected within 30 days.						
V 752	2 27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain water temperatures between 100 - 116 degrees Fahrenheit. The findings are: Observation on 6/11/24 at approximately 10:30am revealed: - the kitchen sink was 94 degrees Fahrenheit - the upstairs hallway bathroom sink and downstairs bathroom sink were 96 degrees Fahrenheit		V 752				
	Observation & Interview with staff #1 on 6/11/24 at approximately 10:30am revealed the following: - a meat thermometer that staff #1 reported she used it to check the water temperatures						
	Interview on 6/13/24 the Qualified Professional reported:						

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHL092-946	B. WING			-C 13/2024
	PROVIDER OR SUPPLIER	3316 MA	DDRESS, CITY, S RCONY WAY I, NC 27610	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 HE APPROPRIATE	(X5) COMPLETE DATE
V 752	- did not think the using got the correc	e thermometer they were ct temperature stitutes a re-cited deficiency	V 752			

Division of Health Service Regulation STATE FORM