| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---|---|-------------------------------|--------------------------|--|
| | | | 7 t. BOILBING. | | F | ₹ | |
| | | MHL092-877 | B. WING | | 1 | 4/2025 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| ABSOLU | ABSOLUTE HOME-PHILLIP STREET 1008 PHILLIP STREET | | | | | | |
| GARNER, NC 27529 | | | | | | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMEN | rs | V 000 | | | | |
| | An annual, complaint and follow up survey was completed on February 24, 2025. The complaint was substantiated (Intake #NC00227017). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. | | | | | | |
| | | | | | | | |
| | | sed for 6 and has a current urvey sample consisted of clients. | | | | | |
| V 115 | 27G .0208 Client S | ervices | V 115 | | | | |
| | 10A NCAC 27G .02 (a) Facilities that prassure that: (1) space and super the safety and welfact) activities are sured; and treatment/habiserved; and (3) clients participal activities. (h) Facilities or progin these Rules as "available 24 hours unless otherwise space (c) Facilities that section is shall ensured (d) When clients what are transported, the with secure adaptive (e) When two or more require special assin a vehicle are transported as the secure adaptive. | 208 CLIENT SERVICES rovide activities for clients shall ervision is provided to ensure are of the clients; itable for the ages, interests, litation 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 hour a physical handicap to equipment. The preschool children who istance with boarding or riding asported in the same vehicle, adult, other than the driver, to | | | | | |

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 | | |
|---|---|---|---|--|--------------------------------|-------------------------------|--|--|
| | | | | | | R | | |
| | | MHL092-877 | B. WING | | 02/2 | 24/2025 | | |
| NAME OF I | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| ABSOLU | TE HOME-PHILLIP S | TREET | LLIP STREET , NC 27529 | Г | | | | |
| (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 ACTI CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | | |
| V 115 | Continued From pa | | V 115 | | | | | |
| | nutritional meals we (#1, #2, #3, #4, #5, Interview on 2/24/2-Been staying in the Been running low of like this since being The Licensee will a they run out. They did not have all they ate was oat Not sure if staff was Client #3 went to the sown money. Staff #1 was working to the facility. His brother took his shop and he had be Mostly kept the food pimento cheese an fridge for everyone were low on food. Interview on 2/24/2-Been living in the food "Runs low on food" they have weeks, but now the | s the facility failed to ensure ere served for six of six clients #6). The findings are: 5 client #1 stated: e facility for about six months. on food for "a while, it's been g here." not bring food in time before food for three to four days and meal. as calling the Licensee or not. he store and bought milk with ng two to three weeks ago and er and he brought them food m out weekly to Walmart to bught food back to the facility. Od in his room, but he did buy d deli meat to keep in the else to have because they 5 client #2 stated: facility for almost two years. | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 E62011 If continuation sheet 2 of 5

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | DER/SUPPLIER/CLIA FICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------------|--|-----------------------------------|-------------------------------|--|
| | | | | A. BUILDING: | | | |
| | MHL | .092-877 | B. WING | | | ⋜ 24/2025 | |
| NAME OF PROVIDER OR SUPPLI | R | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| ARSOLUTE HOME-PHILLIP STREET | | | LIP STREET NC 27529 | Г | | | |
| PREFIX (EACH DEFICIE | | DEFICIENCIES RECEDED BY FULL NG INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| V 115 Continued From | page 2 | | V 115 | | | | |
| -Had bought foo heart." -Had an insurant for the home as -There was a few not have foodStaff #1 called in the homeIf the minister have not had foodThe Licensee withem there was a freezer to eatThe Licensee withem there was a freezer to eatThe Licensee with home as a freezer to eatThe Licensee with home and the clients of some and the clients of someStaff had told his to "stretch" the feorem that all the same insurated in the same insurated interview on 2/24 stated: -Been having issue and the contacted from Tuesday-Fithey did not have she called the Liplanned to take and to come back to state" because of the Licensee minimum that is the called the Liplanned to take and to come back to state" because of the Licensee minimum that is the called the Liplanned to take and to come back to state" because of the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Licensee minimum that is the called the Liplanned to take and the Liplan | out of the "ke e flex card hey did not hey did not he works as a minister what as aware of the more bags of anted them to he more food anything to cowith it, you go "often" because pended on he he that the Licod. To bought food anything to cow the card with a company the food on he with the licod. To bought food ce flex card was food to eat. Censee who could not staff any work and plates the food situat have taken | e used to buy food have anything to eat. ago where they did ho brought food to at food they would ays. he situation and told chicken in the of finish the chicken is cook the chicken et sick of chicken ause they run out him to provide censee will tell them od because he had and worked a job. Ified Professional thome having ek who had worked a upset because said she had day but did not. Indicated she would anned to call "the uation. | V 115 | | | | |

Division of Health Service Regulation

STATE FORM 6899 E62011 If continuation sheet 3 of 5

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|--|------------------------------|-------------------------------|--|
| | | MHL092-877 | B. WING | | | R 24/2025 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | ODRESS, CITY, S | TATE, ZIP CODE | | | |
| ABSOLU | JTE HOME-PHILLIP S | TREET | ILLIP STREET R, NC 27529 | • | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| V 115 | -Had multiple converse months with the Lic low and buying a variable. The Licensee will be provide anything to menu upThe Licensee did rin the facilityHad heard clients at the homeTold the Licensee | ersations over the last few ensee about the food running | V 115 | | | | |
| | exterior requirements of the control | I its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: on and interview the facility | | | | | |
| | and its grounds were clean and attractive Clean and | re not maintained in a safe, manner. The findings are: 00 AM on 2/24/25 revealed front door had 12 broken slats back door had 4 broken slats allway bathroom had 2 broken cheese placed in the hallway in the living room area. The living room was ic with the inside filling coming | | | | | |

Division of Health Service Regulation

STATE FORM 6899 E62011 If continuation sheet 4 of 5

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|--|-------------------------------|--------------------------|
| | | | | R | | |
| | | MHL092-877 | B. WING | | 02/2 | 4/2025 |
| NAME OF | PROVIDER OR SUPPLIER | | STATE, ZIP CODE | | | |
| ABSOLU | ITE HOME-PHILLIP S | IRFFI | LLIP STREE [:] , NC 27529 | ı | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| V 736 | Continued From pa | ige 4 | V 736 | | | |
| | webs and dirt on the Client bathroom si substance in it. Interview on 2/24/2 | ghout were dusty with spider e. nk and shower had black 5 the Qualified Professional | | | | |
| | reported: -She was aware of the needed repairs in the facility -The Licensee/Registered was responsible for overseeing the repairs of the facility -Thought the Licensee had made some repairs since last survey. | | | | | |
| | | been cited 7 times since the /21 and must be corrected | | | | |
| | | | | | | |

6899

Division of Health Service Regulation STATE FORM

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