.

1 2 2

en Nati

ATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY	
የርን ምርጫዋ ና					R-	C
		MHL092-894	B, WING		04/2	6/2025
			DRESS, CITY, ST	ATE, ZIP CODE	v	
AME OF P	ROVIDER OR SUPPLIER		NING STAR DF			
BSOLU	TE HOME - APEX	APEX, N				
		ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION	RECTION	(X6) COMPLET
(X4) ID PREFIX . TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE TO THE CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
V 000	INITIAL COMMEN	лs	V 000			
	April 25, 2025. Th substantiated (Inte	ow up survey was completed on e complaints were akes #NC00226598 & Deficiencies were cited.				
	category: 10A NC Living for Adults v	nsed for the following service AC 27G .5600A Supervised vith Mental Illness.				
	This facility is lice census of 5. The audits of 3 curren	nsed for 6 and has a current survey sample consisted of it clients.				
V 105	5 27G .0201 (A) (1·	-7) Governing Body Policies	V 105	V105 Effective 5/1/25	all employee	
,		0201 GOVERNING BODY		files have been move		
	POLICIES (a) The governing	g body responsible for each shall develop and implement		company office. In the administrator the QP		
	written policies fo	anal Gevelop and important management authority for the		person overseeing op		
	(1) delegation of the f	acility and services;		agency. The QP has a	ccess to the	
	(2) criteria for ad	mission;		office at all times. The	e files will rem	ain
	(3) criteria for dis	charge:		in the company office		
	(4) admission as	sesaments, including:		Prior to the administr		a .
	(A) who will perio	orm the assessment; and for completing assessment.				
	(5) client record (management, including:		meeting will occur be		
	(A) persons auth	orized to document;		and the administrato		
	(B) transporting	ecords;		/ensure that all recon		
	(C) sateguard of	records against loss, tampering se by unauthorized persons;	P*	etc will be available	to the QP at al	ł
	(D) assurance of	f record accessibility to		times during the adm	inistrator's	
	authorized users	at all times; and		absence.		
,	(E) assurance of	confidentiality of records.		ansei rec.		
	(6) screenings, v	vhich shall include:				
	(A) an assessme	ent of the individual's presenting				
	(B) an assessme	ent of whether or not the facility		· · · · · · · · · · · · · · · · · · ·		
ision of	La Ma Condet Decided	A3		TILE		(X6) DATE
ORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVES	STONAL UKE	7 Lia	~ / ~ ~	1



ATEMEN'	of Health Service Re	(Xt) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 04/25/2025	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER,				
		MHL092-894				
AME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
naal it	TE HOME - APEX		ING STAR DF	RIVE		
BSOLU		APEX, NO	27502	PROVIDER'S PLAN OF	CODRECTION	/xK\
(X4) ID PREFIX TAG	(SACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 105	Continued From pa	age 2	V 105	annan allan ann an an Allan ann a		
	This Rule is not m	et as evidenced by: eview and interview, the facility				
	failed to implement	t their policy on delegating ority for the operation of				
	Review on 3/27/25 revealed:	5 of the facility's records				
	Administrator is	hority Policy: "The responsible for allocating relto ensure that quality				
	assurance activitie	es can be accomplished as well lon of the Quality Assurance ministrator (Registered				
	(RN)/Administrato	or/Owner) will be responsible for signate qualified employees to representative in the				
	administrator's ab Home's (facility) A	senceIn the absence of the				
	to the appropriate	ents (clients) care will be referre e senior staff member available.	,			1
	the Qualified Prof Health Service Re	5 of a text message sent from ressional (QP) to the Division of egulation (DHSR) Surveyor on				
	sent me what I re	istrator/Owner] is away. She quested from the employee eck when she will return. I don't	and a second			-
	have access to the records)."	ect when she will found 1 control				NAME OF A REPORT OF
	Interview on 3/18 - The RN/Adm country on a "girl	/25 the QP reported: inistrator/Owner was out of the				

_

PRINTED: 05/12/2025 FORM APPROVED

Division c	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE COMP	LETED
STATEMEN	OF DEFICIENCIES	(X1) PROVIDERSON FLUMBER:			R-	
2010 1 2111	••••		B. WING			5/2025
		MHL092-894			•	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S NING STAR D			
	TE HOME - APEX		C 27502			
		ATEMENT OF DEFICIENCIES	<u>a</u>	PROVIDER'S PLAN OF C	ORRECTION	(XS) COMPLETE
(X4) ID PREFIX . TAG		A EMENT OF DEFOLED BY FULL Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTA CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE
1/400	Continued From p	one 5	V 108			
V 108	1	bchapter, at least one staff			••	
	member shall be a	vallable in the facility at all				1
	times when a clier	nt is present. I hat stan rained in basic first aid		V 108 Personnel Re	quirements	
	including seizure r	nanagement, currently trained	1	Effective immediat	ely after the	
	i sectored to the Mon	which manelNer or other mot a	d	exit (4/25/25) the f	acility	
	techniques such a	is those provided by Red Citos	5 ,	contracted with a (2P for the	
	the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifyli reporting, investigating and controlling infectiou and communicable diseases of personnel and	lieving airway obstruction.		purpose of training	, monitoring	
		a.	and supervision du			
			period following th			
			is restricted from p	roviding		
	clients.			training and oversi		
				contracted QP beg		
				training to the ons	•	
				duty at that time) a		
	mut mut to make	met as evidenced by:		training to the new	-	
	Based on observ	ation, record review and		person for that ho	me.	
	interview, the fac	lity failed to ensure 1 of 4		The facility has dev	veloped a	
	Cerdionulmonao	essional staff (#2) had Resuscitation (CPR) and First	t I	training protocol/p	÷	
	Aid (EA) training	and failed to ensure 2 or 2		be implemented for		
	former naraniofa	staff (#1, #2) and 2 of 3 audite asional staff (FS #3, FS #4) ha		hired and/or relief		
	trainings to meet	MH/DD/SA needs or the client	3	to this home. Prior		
	served. The find	ings are:		providing coverage		
ł	Finding A:			residents the admi		
	Review on 3/19/	25 of staff #2's personnel recol	Ū	ensure that CPR/F/		
	revealed: - Hired 9/21/2 - No documer	4 station of a CPR/FA certificate		medication admin		Lung
	Qualified Profes	25 of an email sent from the sional (QP) to the Division of				
Division o	Health Service Regulat	ion	****	QE0011	if continu	uation sheet 6 of

STATE FORM

 $\int_{\mathbb{T}} |\hat{g}_{i}|^{2} = -\frac{1}{2} |\hat{g}_{i}|^{2} + \frac{1}{2} |\hat{g}_{i}$

.

TATELEN	of Health Service Re FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMP	-
		MHL092-894	B. WING		04/25/2025	
	ROVIDER OR SUPPLIER	109 EVEN	DRESS, CITY, ST		*	
(X4) ID PREFIX TAG	SUMMARY ST	APEX, NO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X8) COMPLET DATE
V 108	revealed: - "I decided to c information. This is previously. I am try aidI'm also check social pop (popula trainings" Review on 3/27/25 the QP to the Divis Regulation Survey - A picture of sta dated 3/26/25 Interview on 3/18/2 - Was a fill-in st facility - Worked for tw and December 20 - Didn't know al started working in - Received CPF employer, but she certificate - Knew the pro- compressions and Finding B: Reviews on 3/13/2 record revealed: - Admitted 9/13 - Diagnoses of Wernicke Enceph and Vitamin D De - A treatment p client #4 had suic	gulation Surveyor on 3/20/25 heck my email for [staff #2]'s a some information I sent you ing to locate herCPR first king my email for supervision, tion), mental health and other of a text message sent from sion of Health Service for on 3/27/25 revealed: aff #2's CPR/FA certificate 25 staff #2 reported: aff and worked alone in the to weeks in October, November 24 bout the clients when she the facility in October 2024 R/FA training with previous didn't have the training cedure for giving chest 1 rescue breaths 25 and 4/25/25 of client #4's W24 and discharged 4/17/25 Altered Mental Status, ialopathy, Alcohol Use Disorder ficiency lan dated 10/9/24 revealed		training and any other to for identified medical di are trained prior to that being allowed to work a Additionally, the QP will complete the following Client Rights, Confidenti Diagnoses/SPMI, Specia Populations, PCP Goals/Treatment Plans/Supervision Assess and Needs, Preventing J Neglect & Exploitation, S Abuse Awareness, Educ Prevention (as needed a if/when this is applicabl Suicide awareness and prevention, incident rep protocols and documen Other trainings to be pre- within the first 30 days of will include; incident rep problem solving and cor resolution, Effective communication and listo skills, cultural competer coping skills.	agnoses t staff lone. trainings: tality, MH l sment Abuse, Substance ation and e) & orting tation. ovided of hire porting, hflict ening	
	revealed: Health Service Regulation			<u></u>		tion sheet 7 o

•

Division o	f Health Service Re			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
OTATELOGIN	OF DEFICIENCIES		Cardian a Michael an animum a	• •		ļ
			ł	-	_	R-C 04/25/2025
	A	MHL092	-894	B. WING		
	ROVIDER OR SUPPLIER				TATE, ZIP CODE	'
				NG STAR DF	RIVE	
ABSOLU	TE HOME - APEX		APEX, NC	27502	PROVIDER'S PLAN OF CORRECT	10N (X6)
(X4) ID PREFIX TAG	SUMMARY STI (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFI Y MUST BE PRECI LSC IDENTIFYING		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	NDRE AAMERCER
V 108	Continued From p	age 7		V 108		
	- Hired 1/24/25				a a terre i de la calle mun muchanett	ulu ada a
	- No documenta	ation of substa	nce abuse		Additionally, when possi	
	awareness and pr	evention trainil	ng Loopulations		newly hired staff will be a	
	training		1		to another home to shad	ow that
Į	- No documente		awareness and		staff in order to have the	
	prevention training) 	ent goal and		opportunity to observe	
	implementation tra	ation of treatm	SUR Storr our		operations and expectati	ons.
	Ť				Going forward the facility	
	Interviews on 3/12	2/25 and 3/14/2	25 staff #1		allow anyone to work alc	
	reported:	in the facilit	y os a live in staff		clients unless they have t	
	1 an OM MS and she	s worked in the	y as a live-in staff facility alone		1 -	
	Know the faci	ility served me	ntal hearn cherics		necessary trainings. This	is the
1	Knew about n	nental health f	rom previous		responsibility of the	
	jobs, but she nev	er worked in a inistrator/Own	er instructed her		administrator.	
	to stay with the cl	ionts showed	her how to		I	
	administer the cli	ents' medicatio	on and "made sure			
	I knew how to tail	k to mental he	aith patients			
	(clients)"	he clients' dia	noses, but she			
	knew the clients'	diagnosas we	e in their records			
	The Decister	ad Muree				
	(RN)/Administrati	or/Owner "dior a) was or their	issues			
	(hohaviors)"			ļ		
	Didn't know y	what a treatme	nt plan was and			
	no one trained he	er on the client	s' treatment plans	v		
	- Was trained prevention	in suicide awa	aticss and			
	- Knew to look	for signs of s	adness or			
	depression	-				**************************************
	Interview on 3/20	0/25 staff #1 re	ported:			
1	- Was current	ty training on a	ubstance abuse		4	
	www.manages.andi	nnevention	eech and the sme			
Į	Knew to look of alcohol for so	k tor siurred sp meone suspec	ted of alcohol use			
Division of	Health Service Regulet	lon				if continuation shawi. 8
				4110	QE0011	

. e S

22 19

STATEMENT OF DEFICIENCIES AND PLAND (**) PROVIDER OF MARGER ADD PLAND, NUMBER MHL092-594 (**) PROVIDER OF MARGER A BULCING AUXIMUM 2 CONTRETOR AUXIMUM 2 CONTRETOR AUXIMUM 2 CONTRETOR AUXIMUM 2 CONTRETOR ADD PLAND, STATE ZP CODE 196 EVENING STAR DRIVE APEX, NC 2502 (**) PROVIDER'S AUX OF CORRECTON (**) CONTRETOR APEX, NC 2502 MULD PROVIDE ROR SUPPLIER STREET ADDRESS, CTV, STATE ZP CODE 196 EVENING STAR DRIVE APEX, NC 2502 (**) PROVIDER'S FLAN OF CORRECTON (**) CONTRETOR APEX, NC 2502 MULD PROVIDE ROR AUXIMITY OR LSG DEPTIFYING INFORMATION TWO TO STATE DEPTIFYING STAR OF CORRECTON (**) CONTRETOR APEX, NC 2502 (**) PROVIDER'S FLAN OF CORRECTON (**) CONTRETOR APEX, NC 2502 V 108 Stande working in the Facility on 21/125 - The RNAdministrator/Owner came to the facility 'sometime that weak' to train her - Received net that weak' to train her - The RNAdministrator/Owner came to the facility 'sometime that weak' to train her - The RNAdministrator/Owner came to the facility 'sometime that weak' to train her - The RNAdministrator/Owner came to the facility to train her on that next 'Monday of Tuesday' - One converted the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2 reported: - Was trained in subclade awareness and prevention and she knew the signs of subchol use were being indentietd, the same of subchol use were being indentietd, the samiron of there a toprevious worked in a group home and had	Division (of Health Service Re	egulation	I ment term ment	CONSTRUCTION	(X3) DATE SURVEY
NUME OF PROVIDER OR SUPPLIER INHIGO2-894 INHIG R-C ABSOLUTE HOME - APEX OTHER ADDRESS, CTTY, STATE ZIP CODE OPUTO OPUT	STATEMEN	T OF DEFICIENCIES	1/X1) PROVIDER/SUPPLIER/CLIA	1		
MHL092-84 B. WHG O4/25/2025 INVESION OF SUPPLIER STREET ADRESS, CITY, STATE, ZIP CODE ABSOLUTE HOME - APEX OP EXAMANY STREMENT OF DEPICIENCIES APEX, NO 27502 PROVIDER OF SUPPLIER TOTA SUMMANY STREMENT OF DEPICIENCIES PROVIDER OF SUPPLIER PROVIDER OF SUPPLIER PROVIDER OF SUPPLIER TOTA PROVIDER OF SUPPLIER ADD EXAMPLE CODE PROVIDER OF SUPPLIER	AND PLAN	UT VURINEV FRUIT		A DURDING.		R-C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NC 27502 APEX, NC 27502 TROMBERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED IN FULL (EACH DEPICIENCY) 00 (METER (EACH DEPICENCY) 00 (METER (EA				B. WING		
ABOLUTE HOME - APEX ABSOLUTE HOME - APEX ADDITIONATION ABSOLUTE HOME - APEX APEX, NC 27692 PRETA C PREVIDENT OF DEPICIENCIES PREVIDENT C REVERDENT OF DEPICIENCY PREVIX PRE				1		
ABSOLUTE HOME - APEX Description MADE APEX, NC 27502 MOD SUMMARY STATURATE OF DEPRETACIES. Interview of LSC IDENTIFYING INFORMATION PREVIDENTS FLANGENEED SY FILL. (EACH CORRECTIVE ACTION SHOULD BE CROBE-REFERENCED TO THE APROPRIATE DEFIDIENCY) Configure CROBE-REFERENCED TO THE APROPRIATE DEFIDIENCY) V 108 Continued From page 8 V 108 DEFIDIENCY) Standa Working in the facility on 2/1/25 - The RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" The RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #21 personnel record revealed: - No documentation of suicide awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol use were being inebriated, the smell of alcohol or motivation or interest - The RN/Administrator/Owner contacted her on 22/125 to work in the facility on 3/14/25, but the RN/Administrator/Owner ontacted her on 22/125 to work in the facility in a 3/14/25, but the RN/Administrator/Owner ontacted her on 22/125 to work in the facility on 3/14/25, but the RN/Administrator/Owner ontacted her on 22/125 to work in the facility on 3/14/25, but the RN/Administrator/Owner ontacted her outcursts, 911 calls or alcohol use in the facility Unterview and observation at 2:04pm on 3/24/25 staff #2 reported: - Proviously worked in a group home and had	NAME OF P	ROVIDER OR SUPPLIER				
KYD ID PREFIX TAQ SUMMARY STATEMENT OF DERCIENCIES (EACH DERCIPACY MUST BE PRECEDED BY FULL) TAQ ID PREFIX TAQ PREFIX (EACH DERCIPACY MUST BE PRECEDED BY FULL) TAQ PREFIX (EACH DERCIPACY (EACH DERCIPACION ACTION BY DERCIPACION) CMM COMPETE (EACH DERCIPACION ACTION BY DERCIPACION) CMM COMPETE (EACH DERCIPACION ACTION (EACH DERCIPACION ACTION ACTION (EACH DERCIPACION ACTION (EACH DERCIPACION (EACH DERCIPACION ACTION (EACH DERCIPACION ACTION (EACH DERCIPACION ACTION (EACH DERCIPACION ACTION (EACH DERCIPACION (EACH DERCIPACION (EAC					RIVE	
KM ID TXG PLACE DEPENDENCY WIST BE PRECEDED BY FULL REGULTORY OR USCIDENTIFYING INFORMATION) PRETX TXG PRETX CROSE REFERENCED TO THE APPROPRIATE DEPICENCY; COMMENT OR USCIDENTIFYING INFORMATION) V 108 Continued From page 8 V 108 - Knew the client's information was in their record's V 108 V 108 Interview on 4/11/25 staff #1 reported: - Started working in the facility on 2/125 V 108 - Knew the client's information was in their record's Contained From page 8 V 108 - Knew the client's information was in their record's Contained From page 8 V 108 - Knew the client's tory was not be the facility 'sometime that week' to train her Receiled her police with the client's record whenever they came to the facility record whenever they came to the facility Review on 3/18/25 staff #2 reported: - No documentation of suicide evareness and prevention and she knew the signs of alcohol use were being Interiated was buse awareness and prevention and she knew the signs of alcohol use were being interiated, the semil of alcohol or being lettnargic - Previously as the client's treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility outbursts, 911 calls or alcohol use in the facility Interview and observation at 2/04pm on 3/24/25 staff #2 reported. - Previously worked in a group home and had	ABSOLU	TE HOME - APEX	APEX, N	27502		
 Vide Contribute From page 0 - Knew the client's information was in their records Interview on 4/11/25 staff #1 reported: Started working in the facility on 2/1/25 The RN/Administrator/Owner came to the facility 'sometime that week'' to train her Recalled her first day was on a Friday & '' think' the RN/Administrator/Owner came to the facility 'sometime that week'' to train her Recalled her first day was on a Friday & '' The RN/Administrator/Owner came to the facility to train her on that next 'Monday or Tuesday'' She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: Was trained in subcide awareness and prevention raining Interview and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of alcohol us were being inhebriated, the smell of alcohol us the facility in 2/1/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner constacted her on 2/2/1/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner constacted her on 2/2/1/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner constacted her on 2/2/1/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner constacted her on 2/2/1/25 to work in the facility on 3/14/25, but the facility on 3/14/25, but the facility Section all 2/04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
Knew the client's information was in their records Interview on 4/11/25 staff #1 reported; Started working in the facility on 2/1/25 The RN/Administrator/Owner came to the facility "sometime that week" to train her Recalled her first day was on a Friday & "1 think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed; No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported; Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of slucidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of slucidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of slucidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention must be signed slucidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the facility on 3/14/25, but the RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/24/25, but the RN/Administrator/Owner don'n the facility Interview and observation at 2/04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had	V 108	Continued From pr	ade 8	V 108		
records Interview on 4/11/25 staff #1 reported: Started working in the facility on 21/25 The RN/Administrator/Owner came to the facility "sometime that week" to train her Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on thet next "Monday or Tuesday" She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: Not documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation ware depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of suicidal ideation ware depression, crying, lack of motivation or interest The SN/Administrator/Owner contacted her con 22/125 to work in the facility on 3/24/25, but the RN/Administrator/Owner contacted her con 22/125 to work in the facility on 3/24/25 staff #2 reported: Division Of Health Serve Reguistion Division Of Health Serve Reguistion	¥ 194					
Interview on 4/11/25 staff #1 reported: - Started working in the facility on 2/1/25 - The RN/Administrator/Owner came to the facility 'sometime that week' to train her - Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - The RN/Administrator/Owner contacted her on 22/1/25 to work in the facility on 3/1/25, but the RN/Administrator/Owner contacted her - The RN/Administrator/Owner contacted her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of results Beruse Regulation		£	ts mornadon was in their			
- Started working in the facility on 2/1/25 - The RN/Administrator/Owner came to the facility "sometime that week" to train her - Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol or being lethargic - Previously saw the client's treatment plans in the client' records, but no or retrained plans in the RN/Administrator/Owner contacted her on 22/1/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner dignt inform her about client #4 is elopement, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Servee Regulation		1900/03				
The RN/Administrator/Owner came to the facility "sometime that week" to train her Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: Was trained in sulcide awareness and prevention training Interview on 3/18/25 staff #2 reported: Was trained in sulcide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inhebriated, the smell of alcohol or being lethargic Previously saw the client's treatment plans in the clients' records, but no one reviewed the treatment plans with her The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4 se lopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had	100 Y	Interview on 4/11/2	25 staff #1 reported:			
facility "sometime that week" to train her - Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her abut client first acohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		- Started working	ig in the facility on 2/1/25			Ì
Recalled her first day was on a Friday & "I think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of suicidal ideation were being inebriated, the smell of alcohol use were being inebriated the facility The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner doft's, but the RN/Administrator		- The RN/Admin	histrator/Owner came to the			
think" the RN/Administrator/Owner came to the facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		facility "sometime	inat week to training inst day was on a Friday & "I			
facility to train her on that next "Monday or Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner dign't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		think" the RN/Adm	inistrator/Owner came to the			
Tuesday" - She provided the police with the client's record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		facility to train her	on that next "Monday or			
record whenever they came to the facility Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		Tuesdav"				
Review on 4/1/25 of staff #2's personnel record revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		- She provided	the police with the client's			
revealed: - No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being Inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Healin Service Regulation		record whenever t	they came to the facility			1
No documentation of suicide awareness and prevention training Interview on 3/18/25 staff #2 reported: Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had		Review on 4/1/25	of staff #2's personnel record			
prevention training Interview on 3/18/25 staff #2 reported: - Was trained in suicide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - - Previously worked in a group home and had		revealed:	ation of suicide awareness and			
Was trained in sulcide awareness and prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had Division of Health Service Regulation						
prevention and she knew the signs of suicidal ideation were depression, crying, lack of motivation or interest - - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - - Previously worked in a group home and had -		Interview on 3/18/	25 staff #2 reported:			
ideation were depression, crying, lack of motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		- Was trained i	n suicide awareness and			
motivation or interest - Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		prevention and sh	he knew the signs of suicidal			
Was trained in substance abuse awareness and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had Division of Health Service Regulation		ideation were dep	ression, crying, lack of			
and prevention and she knew the signs of alcohol use were being inebriated, the smell of alcohol or being lethargic - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		- Was trained i	n substance abuse awareness			
Use were being inebriated, the smell of alcohol or being lethargic - - Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - - Previously worked in a group home and had		and prevention an	nd she knew the signs of alcoho	ol		
being lethargic Previously saw the clients' treatment plans in the clients' records, but no one reviewed the treatment plans with her The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: Previously worked in a group home and had Division of Health Service Regulation		use were being in	ebriated, the smell of alcohol o	r		
the clients' records, but no one reviewed the treatment plans with her . The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: . Previously worked in a group home and had .		being lethargic				
treatment plans with her - The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		- Previously sa	w the clients' treatment plans if	1		
The RN/Administrator/Owner contacted her on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation				verez cherte		
on 2/21/25 to work in the facility on 3/14/25, but the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		The RN/Adm	inistrator/Owner contacted her			
the RN/Administrator/Owner didn't inform her about client #4's elopements, behavioral outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		on 2/21/25 to wor	k in the facility on 3/14/25, but			
outbursts, 911 calls or alcohol use in the facility Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation		the RN/Administr	ator/Owner didn't inform her			2 6 - 1
Interview and observation at 2:04pm on 3/24/25 staff #2 reported: - Previously worked in a group home and had		about client #4's	elopements, behavioral			000000000 V
staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation If continuation sheat 9 of 1		outbursts, 911 ca	his of alconol use in the facility			1
staff #2 reported: - Previously worked in a group home and had Division of Health Service Regulation If continuation sheat 9 of 1	1	Interview and obs	servation at 2:04pm on 3/24/25			
- Previously worked in a group home and had Division of Health Service Regulation If continuation sheat 9 of 1	ł	staff #2 reported:				
		- Previously W	orked in a group home and had			
			n	5323	QE0011	If continuation sheet 9 of 1

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R-C		
		MHL092-894	B. WING		04/	04/25/2025	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ABSOLU	TE HOME - APEX		IING STAR D	RIVE			
		APEX, NO	T				
(X4) ID PRÉFIX 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	(XS) COMPLET DATE	
V 108	Continued From pa	age 10	V 108				
	(2025)"	•					
	Review on 4/1/25 revealed: - Hired 5/1/24 - No documenta awareness and pre - No documenta training - No documenta training - No documenta implementation tra	tion of supervision of needs tion of special population tion of treatment goals and ining					
	reported: - Started workin, hadn't worked in th - Knew client #4 and suicidal ideatic - Was trained or and prevention, clie suicide awareness	n substance abuse awareness ant's supervision needs and					
	strategies of all of t the clients' behavio - The QP was "v trainings)" - Knew the clien records and she ga	he clients' treatment plans and					
	with the local Police - Concerned the clients - "Workers (staff information about t know where the inf	5 the Crisis Intervention Team 5 Department (PD) reported: 5 staff weren't trained on the 6) don't know enough the clients" and the staff "don't formation is" 10 tequipped to know where					

STATE FORM

6890

AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDERSUFFICIENCER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R-C 04/25/2028	
	ROVIDER OR SUPPLIER TE HOME - APEX	MHLU92-004 STREET ADD	REGS, CITY, ST	TATE, ZIP CODE RI VE	······································	
(X4) ID PREFIX . TAG	AT A CHARGE METHODE MAN	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE	(X5) COMPLET DATE
	number so she cou October 2024, but staff #2 completed - Hadn't receive knowing the client: requested by the p - She instructed provided the Polici information when the Interview on 4/17/2 reported: - The QP was r suicide awareness needs, treatment substance abuse - The QP condu- staffs' certificates - Was unaware special population prevention, super and implementativ awareness and put This deficiency is NCAC 27G .0203 Professionals and (V109) for a Type within 23 days. 9 27G .0203 Privile 10A NCAC 27G . QUALIFIED PRC ASSOCIATE PR	#2 the CPR/FA instructor's uid schedule her training in she didn't follow up to see if the training d any reports of the staff not a' information when it's oolice i staff to contact her and she e Officers the client's they arrived at the facility 25 the RN/Administrator/Owner esponsible for training staff on s and prevention, supervision of goals and implementation and awareness and prevention ucted the trainings and put the in their personnel records e some staff were not trained in h, suicide awareness and vision of needs, treatment goals on and substance abuse revention cross referenced into 10A 3 Competencies of Qualified d Associate Professionals A1 and must be corrected eging/Training Professionals (0203 COMPETENCIES OF DFESSIONALS AND	V 108 V 109	V109 privileging/T Professionals The information the referenced in this being available is a in the form of Med Administration red therefore medicate available 100% of are the document to document med administration on and in most cases per day. It appear Police Department filling a missing per differs from other Typically when a re only one phone ca person missing is facility administrate understand that the different for this of	hat is report as not readily available dication cords and tion records are the time. These is that staff use lication a daily basis several times s that Apex it's protocol for inson report yurisdictions. report is made all to report the required. The ator and QP the policy is	

STATE FORM

. .

si. Nanji

Division	of Health Service Re	equilation			(X3) DATE SURVEY
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	COMPLETED
AND PLAN	OF CORRECTION	IFICATION IN LONG INTRODUCTOR	A. BUILDING:	A company of the second statement of the second statement of the second statement of the second statement of the	
			-		R-C 04/25/2025
		MHL092-894	8. WING		
	ROVIDER OR SUPPLIER	STREETAD	RESS, CITY, S	STATE, ZIP CODE	*
NAME OF F	KONNER OK SOFFER		NG STAR D		
ABSOLU	TE HOME - APEX	APEX, NC			(i)
(X4) ID PREFIX TAG		NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLEXE
V 109	 (b) Qualified profe professionals shall and abilities require (c) At such time as employment system then qualified profe professionals shall (d) Competence s exhibiting core skiil (1) technical know (2) cultural aware (3) analytical skills (4) decision-makii (5) interpersonal si (6) communication (7) clinical skills. (e) Qualified profe NCAC 27G .0104 met the requirement employment system MH/DD/SAS. (f) The governing develop and imple for the initiation of plan upon hiring et (g) The associate supervised by a q population served 	ssionals and associate demonstrate knowledge, skills ad by the population served. s a competency-based m is established by rulemaking, assionals and associate i demonstrate competence. shall be demonstrated by is including: viedge; ness; s; ng; skills;	V 109	Going forward to ensure the report has been made, the reporting facility administed QP or staff will now ensure there is a report # provided the police department to facility. This will indicate the report has been filed. Additionally, any allegated abuse, neglect or exploited be reported within the reporting time limits.	e rator, e that ed by the hat a ons of tion will
ris dalar of	Resed on record	net as evidenced by: review and interview, the facility of 2 Qualified Professionals ed Nurse			
Division of		л і	6337	QE0011	If continuation shoet 15 of 1

STATE FORM

•

4

.

Ø 011

PRINTED: 05/12/2025 FORM APPROVED

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL092-894	B. WING		R-C 04/25/2025	
	PROVIDER OR SUPPLIER JTE HOME - APEX		ING STAR D	TATE, ZIP CODE RIVE	£	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	n RF	(X5) Complete Date
	 F. Cross reference: Personnel Registry review and interview an allegation of neg failed to report the Health Care Person days of being notifie G. Cross reference Supervised Living fa -Operations (V291) record review and it ensure service coor between the facility Professionals response treatment/habilitation (#4). H. Cross reference: Incident Response I and B Providers (V3 record reviews, and 	G.S. §131E-256 Health Care (V132). Based on record w, the facility failed to ensure lect was investigated and allegation of neglect to the mel Registry (HCPR) within 5 ad. 10A NCAC 27G .5603 or Adults with Mentai Iliness Based on observation, nterview, the facility failed to dination was maintained operator and the Qualified msible for n for 1 of 3 audited clients 10A NCAC 27G .0603 Requirements for Category A 666). Based on observation, interviews, the facility failed s governing their response to	V 109	There is a statement in the r made by the officer that "it is appear that the staff or administrator cared that the client was missing" that was more opinionated than fact. The administrator initiated to report and the requested information would have bee available in documentation to was present on the premises the form of the medication administration records.	didn't ual. he n	
	Cross reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on observation, record aviews and interviews, the facility failed to ensure incident reports were submitted to the local Management Entity (LME)/Managed Care Organization (MCO) within 72 and 24 hours as equired. Cross reference: 10A NCAC 27D .0101 Policy n Rights Restrictions and Interventions (V500).			A full time staff has been hired for that home and is scheduled begin work during the 2 nd wee of May. She has had all the required trainings and knows what information is needed an where to locate information. Th	d to k	
	Based on record revi failed to report all inc	ew and interview, the facility idents of alleged neglect to ent of Social Services (DSS)		contracted QP will provide additional training		

STATE FORM

5889

QE0011

If continuation sheet 17 of 170

TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 04/25/2025	
		MHL092-894				
	ROVIDER OR SUPPLIER TE HOME - APEX	109 EVEN APEX, NO	ING STAR DI	TATE, ZIP CODE RIVE PROVIDER'S PLAN OF CORRI		()(5)
(X4) ID PREFIX TAG	AT A OLD NEEL OR AND A DATE	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULDBE	DATE
V 109	Agency) standards service." Review on 4/1/25 of RN/Administrator/0 revealed: - Hired 11/13/09 - A signed job d revealed the follow responsibilities: - "Maintains an with all staff, resid - "Provides clini his/her supervision - "Schedules ar as needed with tre - "Reports incld guidelines." - "Provides clini acquisition, retent related to activities adaptive skills." - "Provides clini habilitation, traintr with elements of a engaging participa training, and other the course of the and supervision of sustain skille gain - "Provides clini interactions with t achieve outcome: - "Provides clini interactions with t achieve outcome:	specified by [Government and any other funding of the Dwner's personnel record escription dated 12/10/18 ving Administrator open line of communication ents and families." cat oversight for homes under n." d participates in team meetings eatment" ents as required by state ical supervision to ensure ion or improvement in skills a of daily living and social and ical supervision to ensure that og and instruction are coupled support, supervision and ation to reflect the natural flow of r activities as they occur during person's day and that support f the person's activities to ed is provided." ical supervision to ensure the he person are designed to s identified in the plan of care." ical supervision to ensure ment interventions to ensure the he person are designed to s identified in the plan of care." ical supervision to ensure ment interventions to ensure the ires skills necessary to or remediate functional problems person-centered plan	Ar − − − − − − − − − − − − − − − − − − −	Another concern is that report mentions that the guardianship agency co- reached. In the many ye we have dealt with that particular agency, neve- was there a problem co- the on-call person. Call been made to that prov- different hours of the d- including calls made to after midnight and the always been answered returned immediately.	e uld not be ears that r, ever ntacting s have ider at ay, them calls have	

٠

3. 1 - A A

STATEMENT OF DEI AND PLAN OF CORF	ICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	···	MHL092-894	B. WING			R-C 04/25/2025	
NAME OF PROVIDE	R OR SUPPLIER	STREET AC	DDRESS, CITY, S	TATE, ZIP CODE			
ABSOLUTE HOM	IE - APEX	109 EVEI APEX, N	NING STAR DI C 27502	RIVE			
(X4) ID PREFIX (E/ TAG RE(ACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
2/20/2 RN/Ad - He paraph RN/Ad - Ha determ the wo #4's pr - Co RN/Ad (client - - "It RN/Ad for sum - Did altering 2/20/25 didn't g - Att guardia #4's gu - The spoke t she still informa that nig - Did altering when th reported - Client as a mit - Inst	wrote the 2/ irrased the co ministrator/O id to review h ine if the RN rd "regularly" evious elope uld tell "no or ministrator/O #4) was gone didn't seem 1 ministrator/O #1 was gone didn't seem 1 ministrator/O #1 was gone didn't seem 1 medicine" o because the ive him client empted to ca in to get client ardian didn't e RN/Adminit o client #4's I didn't provid tion Center dinto tion Center (ht (2/20/25)" n't know clien medicine" or is RN/Adminit client #4 sti ent #4 was en ssing person ructed the RI the police in	ke with the wher at the facility 20/25 police report, but he inversation he had with the wher is body camera footage to /Administrator/Owner used when she spoke about client ments from the facility ne (staff #1 or wher) was surprised she at whethey (staff #1 or wher) was surprised she at whethey (staff #1 or wher) cared, but I can't say nt #4 "was taking mind r client #4's diagnosis on a RN/Administrator/Owner t #4's information II client #4's private agency at #4's information, but client answer strator/Owner stated that she private agency guardian, but le him with client #4's ent #4]'s mental statusIf I would have been put in the the National Crime NCIC) as a missing person) at #4 was taking "mind ther diagnoses until 2/24/25 istrator/Owner called and II missing thered into the NCIC system	V 109				

STATE FORM

6690

QE0011

If continuation sheet 21 of 170

(X4) ID SUMMART STATEMENT OF SUCH CORE	
Image: Construction of the second state second state second state of the second state of the se	0-1720/20/20
(X4) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER (EACH CORR (EACH CORR TAG V 109 Continued From page 22 V 109 Interview on 4/25/25 the QP reported: - The RN/Administrator/Owner knew client #4's Information - The RN/Administrator/Owner was at the facility on 2/20/25 and RN/Administrator/Owner had to give the police client #4's Information V 109 Interview on 4/1/25 the RN/Administrator/Owner had to give the police client #4's Information Interview on 4/1/25 the RN/Administrator/Owner reported: - Staff #1 called her and said client #4 left the facility on 2/20/25 - She called 911 to the facility - She called 911 to the facility - She called 11 to the facility - She called 11 to the facility - She called telling the Police Officers, but she didn't tell the Police Officers client #4 left the facility "regularly" - Recalled telling the Police Officer that client #4 went missing, but "Istaff #11 did mention she (client #4) left the house1 or 2 times before" - Was unaware client #4 had previously eloped from the facility - She gave the Police Officers client #4's medication and diagnoses, but "the police said they don't feel she's (client #4) in immediate danger and they won't going to make a report unless she didn't return in 48 hoursIf she comes back before 48 hours let them know" - "Thought" the police were going to come back to	
(X4) ID IDMMART SITEMAT SUMMART SITEMAT PRECISE PRECISE (EACH CORF TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFER V 109 Continued From page 22 V 109 V 109 V 109 Interview on 4/25/25 the QP reported: - The RN/Administrator/Owner knew client #4's Information - The RN/Administrator/Owner was at the facility on 2/20/25 and RN/Administrator/Owner had to give the police client #4's Information Interview on 4/1/25 the RN/Administrator/Owner reported: - Staff #1 called her and said client #4 left the facility on 2/20/25 - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 to the facility - She called 911 - - She called telling the Police Officers that client #4 - - Wasunaware	
 Interview on 4/25/25 the QP reported: The RN/Administrator/Owner knew client #4's information The RN/Administrator/Owner was at the facility on 2/20/25 and RN/Administrator/Owner had to give the police client #4's information Interview on 4/1/25 the RN/Administrator/Owner reported: Staff #1 called her and said client #4 left the facility on 2/20/25 She called 911 to the facility She called 911 to the facility to help search for client #4 She spoke with the Police Officers, but she didn't tell the Police Officers client #4 left the facility "regularly" Recalled telling the Police Officer that client #4 went missing, but "Istaff #1] did mention she (client #4) left the house1 or 2 times before" Was unaware client #4 had previously eloped from the facility She gave the Police Officers client #4's medication and diagnoses, but "the police said they don't feel she's (client #4) in immediate danger and they won't going to make a report unless she didn't return in 48 hoursIf she comes back before 48 hours left them know" "Thought" the police were going to come back to police were going to co	RS PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE COMPLETE ENCED TO THE APPROPRIATE DATE DEFICIENCY)
 The RN/Administrator/Owner knew client #4's Information The RN/Administrator/Owner was at the facility on 2/20/25 and RN/Administrator/Owner had to give the police client #4's Information Interview on 4/1/25 the RN/Administrator/Owner reported: Staff #1 called her and said client #4 left the facility on 2/20/25 She called 911 to the facility She came to the facility to help search for client #4 She spoke with the Police Officers, but she didn't tell the Police Officers client #4 left the facility "regularly" Recalled telling the Police Officer that client #4 went missing, but "[staff #1] did mention she (client #4) left the house1 or 2 times before" Was unaware client #4 had previously eloped from the facility She gave the Police Officers client #4's medication and diagnoses, but "the police said they don't feel she's (client #4) in immediate danger and they won't going to make a report unless she didn't terturn in 48 hoursIf she comes back before 48 hours left them know" 	
 "After a few days, I asked staff (staff #1) if the police showed up. When she said 'no,' I called the police" to report client #4 missing on 2/24/25 Interview on 4/25/25 the RN/Administrator/Owner reported: The Police Officers from the PD were "lying" 	

TATEMENT	f Health Service Re of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	eted C
		MHL092-894	B. WING		04/2	5/2025
	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
		109 EVEN	IING STAR DR	RIVE		
ABSOLU	TE HOME - APEX	APEX, NO	27502			/V#\
(X4) ID PREFIX TAG	いいものい わただいたばいし	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 1812	(X5) COMPLET DATE
V 109	Continued From p	age 28	V 109			
	guardianship infor The RN/Administr notify the police in the facility or not, waited over 24 ho to contact the poli returned and clier NCIC as a missin was located by th neighboring city a 2/26/25. Client #4 2/20/25 to 2/26/20 RN/Administrator physicians about reported client #4 alcohol use to the the RN/Administr any changes in th not notify client #1 use. The RN/Administr	mation when it was requested. ator/Owner was instructed to 48 hours if client #4 returned to but the RN/Administrator/Owner urs past the instructed time limit ce to say client #4 hadn't it #4 was not entered into the g person until 2/24/25. Client #4 e police at a hotel in a ind returned to the facility on missed her medications from				
	displayed aggres Clients #1 and # which led to a ph called to the faci committed. Her which was high mental impairme Clients #1, #3 al unsupervised tin #3 left the client and she was no deescalate an a	nd #4 did not have approved ne in the facility. On 1/12/25, Fi s alone in the facility for an hour t present in the facility to Itercation between clients #1 an	n S d			
	#4. Clients #1 a	nd #4 got into a verbal altercation lled the police on client #1. The rgency Medical Service arrived	n			tion sheet 29

¢899

QE0011

TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		MHL092-884	B. WING		04/25/2025	
IAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE. ZIP CODE	i	
BSOLU	TE HOME - APEX	APEX, NC			CTION (X5)	
(X4) ID PREFIX TAG	AND A COLD THE COMPANY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		
V 112	Continued From pa	age 30	V 112	V112 Assessment/Tre Plan Client #4 has been dis		
				of 4/17/25. Client #1	-	
	Based on observa Interview, the facili implement goals a needs of 1 of 5 cli Reviews on 3/13/2 record revealed; - Admitted 9/13 - Diagnoses of Wemicke Encept and Vitamin D De - A treatment p the Qualified Prof statement: "The f	lan dated 10/9/24 was signed by ressional after the following following signature confirms the he Qualified		functioning at baselin newly hired staff, terr assigned staff have be inserviced on repo protocols. For any clie incident requiring trea necessitating attentio involving police, relate behaviors (including s abuse, leaving withou notification, fighting, a threatening, etc) sho	iporarily been or will rting ent related atment, n by EMS, ed to ubstance it arguing, ould be	
	Professional/Lice the development Plan). This signar the services/supp - The treatmen strategies to dec aggressive beha homicidal ideatio emergency servi - Goal #1: - The goal list - "[Client #1 supports regular discussion of ne [Client #4] will pa	nsed Professional (QP/LP) for of this PCP (Person Centered bure indicates agreement with ports to be provided." Int plan contained the goals and rease client #4's alcohol use, viors, suicidal ideations (SI), ns (HI) and excessive use of		reported to the QP. The entails the reporting p The QP will follow up Treatment plans addr needs of clients. They updated as necessary behavior has been det cause a detriment (or the health and/or safe resident or others in t residence or commun	protocols. as needed. ess current will be when a termined to possible) to ety of any he	

STATE FORM

* $\mathcal{L}_{\mathcal{L}}$

Ś

_

PRINTED: 05/12/2025 FORM APPROVED

OTATEMENT.	f Health Service R	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE COMPL	ETED
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:			R-	C 5/2025
		MHL092-894	B. WING		, UNX	
		STREETA	DDRESS, CITY, S	TATE, ZIP CODE	r	
	ROVIDER OR SUPPLIER	109 EVE	NING STAR DI	RIVE		
ABSOLU	TE HOME - APEX		IC 27502			(20)
(X4) iD PRÉFIX TAG		ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE	(XS) COMPLET DATE
V 112	Continued From p	bage 32	V 112	staff have been inse	erviced on	
	/Emorephy Med	ical Services) in order to leave		treatment plans an	đ	
	the facility when s	the is angry or wants to self		understanding inter	ventions. in	:
	medicate "	d the following strategies:		the future the QP w		t t
	"IClient#	A) will meet with protessional		whether a staff is a		:
	supports regulari	y in order to facilitate honest de end communicate progress		the information.	· — ·• • • ₩*******	
	Inclient #41 will tai	k with providers as needed whe	en _			
	i cho foelie en inch	ease in her symptoms or is symptoms. [Client #4] will be				
	onen to research	ing information on diagnoses,				
	illnesses and me	dical conditions. She will				
	participate in the	treatment process and t effort to gain insight into her				
	illnesses through	discussion, research,	•	If it is determined t	hat the staff	
	wolugtions of	4	m	if it is determined to person is not able t		
	- "Resider	ntial QP will provide the followir poprtive counseling.	9			
	identification of t	partiers to skill development,		goals and/or interv		
	i referral linkage 8	and identification to resources		outlined in the trea	rment plan	
	that can assist C	lient including medication vill provide coordination and		then it should be d		
	- aumentable of initia	al and onnoing assessment		that the person is i	ncapable of	
	antivities and all	na development, implementauu	n	continuing employ	ment and this	
		of the PCP, assessing progress ide guidance to other Resident	2 (will be communica	ted. Whenever	
1	etoff and profest	sionals and consultation with		it has been determ	nined that the	
	Ather healthcate	nroviders, facilitate planting	n	facility is unable to	o meet the	
	meetings as we	Il as frequently inform [client #4 f services, needs and progress		needs of client for	any reason the	
	OP will meet wi	th client no less than monthly it)r i	facility will first se		
	aeneral discuss	ion of mental health needs and	1	support from the	mental health	
	progress. QP w	Ill inquire about symptoms and on developing strategies to	,	provider, the LME		
ł	manage sympt(oms."		guardian, family,		
	- "Reside	ntial staff will administer		5vu unit (144107)		
	medications as	prescribed by client's medical will document all psychotic				
	habeviors behi	avioral outbursts, Verbai				
	aggression and					

14 C . .

TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	RECTION (X1) PROVIDER/SOPPLIES/CLEA IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED R-C 04/26/2021	
	ROVIDER OR SUPPLIER	109 EVE	DDRESS, CITY, ST NING STAR DE C 27502	RIVE	ج <u>معہ</u> کر میں	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	NLD BE	(X5) COMPLETE DATE
V 112	identification of ba referral linkage an that can assist Clill evaluation. QP will oversight of Initial activities, ongoing and monitoring of and needs, provid staff and professik healthcare provide as well as frequen providers of servid "Staff will outbursts, verbal is (making poor cho necessary suppor educational progr encouragement to Staff will encourage that provide 'happ Residential Sup following interven activities she enjo options to choose verbal prompting client in preparing activities. Staff will act support her as ne necessary suppo begins the proces vocational rehabi education, impro- skills or perhaps parenting skills tr be a grandmothe - Goal 4:	portive counseling, mers to skill development, d identification to resources ant including medication I provide coordination and and ongoing assessment development, implementation the PCP, assessing progress e guidance to other Residentia onals and consult with other ars, facility planning meetings itly inform [client #4] and ces, needs and progress." ill document all behavioral aggression and noncompliance ices)Staff will provide t toenroll in social or am. Provide prompting and o begin registration process. ge [client #4] to make choices port Staff will provide the tions: Will assist client in findin bys. Staff will provide client with o from as well as encourage, and redirection in assisting ther scheduled preferred il assist and encourage client to vities during the course of the company client to activities and aeded. Staff will provide in and encouragement as clien as of getting involved in litation, volunteerism or pursuli ving social or independent livin she might want to focus on aining (given that she will soor	g g i t g	If the issue or behavior is that the facility adminis not longer able to provi- environment for any pe the resident then a noti- discharge will be issued and including immediat discharge, if it has been determined that the bel- involves concern for life others.	tration is de a safe rson at ce of , up to e navior	

Division o	f Health Service Re		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			
AND PLAN S			-		R-	
			B. WING		04/2	5/2025
		MHL092-894				
	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
			ING STAR DR	live .		
ABSOLU	TE HOME - APEX	APEX, NO	27502			(X5)
	SUBMARY ST		ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LDBE	COMPLETE
(X4) ID PREFIX		V MAIGT SE PRECEDED ST FULL	PREFIX	CROSS REFERENCED TO THE APPRIL	PRIATE	DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		DEFICIENCY		
V 112	Continued From p	age 36	V 112			Ì
		She will complete housekeeping				
	necessary nemo.	h minimum prompting. She will				
	he cupanticed at a	all times when beyond the				
ĺ	mailhov at the aro	up home. She will not be				
	annroved for UDSI	pervised time in the community				
	ot this time "					
	- "Resident	tial QP will provide the following				
	interventions' Suc	portive counseling,				
	Identification of b	arriers to skill development,				1
	referral linkage at	nd identification to resources				ļ
	i that can assist cli	Ant. OP WIII provide coordination	1			1
	and oversight of i	nitial and ondoing assessment				
	activities, ongoing	development, implementation				l
	i and monitoring of	FINA PCP, arranging services,	_			
	assessing progre	ss and needs, ensuring service	•			1
	are continuous a	nd matched to level of need,				ļ
	provide guidance	to other Residential staff and				
	professionals and	d consultation with other lers, facilitate planning meetings				1
	neanncare provid	ntly inform [client #4] and	-			
	as well as ifeque	ices, needs and progress,"				1
	A Crisis Draw	vention and Intervention plan				
	included in the fr	eatment plan revealed the				
	following:					
1	 "Significant e 	event(s) that may create	*****			
	increased stress	and trigger the onset of a				
	crisisIClient #4] will demonstrate loud,				ļ
	threatening and	offensive language, She IS				1
	confrontation W	ill should racial siurs in an error				
	to encage the pe	erson in an argument. Make tais	e i			-
	statements whe	n she wants to avoid situations."	***			1
1	 "Crisis preve 	ention and early intervention	***			
	strategies that w	vere effective Talk to her in a				*
	calm manner. V	alidate her thoughts or ideas if				
	that's appropriat	e. Encourage involvement in	s			****
	activities. Encou	Irage her to practice coping skill	~			4 -
	(deep breathing	, talking). Monitor closely when	*			v munocov
	she reports beir	ig depressed or seems to				
	becomes more	active. You don't have to agree I't disagree when she is angry o	-	1		
	With her but don	It grody co mort and to wight of	į			
Division 0	f Health Service Regula	UUII		00001	if continus	ation sheet 37 of

Division (of Health Service Re	gulation		CONSTRUCTION	(X3) DATE	SURVEY
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP	LETED
AND PLAN	OF CORRECTION	IDEM DERMICHTER DERMISSEU.	A. BUILDING: .		R	.c
			CT LABLES			5/2025
		MHL092-894	B. WING		1 1444	a ale a species and see the
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NAME OF P	KOVIDER OK SUFFLIER		ING STAR D			
ABSOLU	TE HOME - APEX	APEX, NO				
			ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	PREFIX	WACH CORRECTIVE ACTI	ON SHOULD BE	COMPLETE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		
V 112	Continued From pa	age 38	V 112			
V 1146	· · · · · ·					
	professionals and	consultation with other				
	healthcare provide	rs informing them of client #4's				
	needs and progres	is while montings with the OP				
	 Scheduled moduled moduled	inthly meetings with the QP				
	Client #4's inc	reased symptoms of				
	depression suicid	al ideation and threats of				
	self-harm					
	- Client #4's bel	havioral outbursts, verbal				
	addressions and r	oncompliance				
	- Client #4's exc	cessive use of emergency				ļ
	services					
	 Strategies dev 	veloped to manage symptoms				Į
	- Staff encoura	ging client #4 to participate in				
	making snacks, ill	th meal preparation, ies or schedules and monthly				
		les or solieoules and mornay	•			
	budgeting	t plan did not have goals or				
	stratenies to addr	ess client #4's elopement				4
	behavior					
						Ì
	Finding A: Examp	les of how the facility failed to				
	implement client	#4's treatment plan	Í			1
						1
	Observations beh	ween 11:29am and 3:00pm on				
	3/12/25 revealed:	- shares and althou in has hadroor	m			
	- Client #4 was	observed either in her bedroor				
	or outside smokin	ng on the front porch an't engaged in any structured				
	activities	urr Auffaffan ur mut an Aorai an	rann, sp. 4 444			1
	douvindo					
	Interview on 3/12	/25 client #4 reported:				1
	- Didn't do any	educational, recreational or				•
1	social activities		10. Yr 10.000			
		anything but sit around in the				****
	facility	a a a a a a a a a a a a a a a a a a a	******			1
	- Most staff the	at worked in the facility didn't				
	have a car to trai	hsport the clients anywhere, but	L			4
		r and she would take her to the				-
l	store					······································

Division	of Health Service Re	agulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	٢
			A. BUILDING:			
		MHL092-894	B. WING		R-C 04/25/202	5
		STREET AD	DRESS CITY S	TATE, ZIP CODE	s	
			NING STAR D			
ABSOLU	TE HOME - APEX	ÁPEX, NO				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMP	LETE
V 112	Continued From pa	ge 40	V 112	ан алтан байна тараан байн түрээн байн т	**************************************	
	 She started betwriting things down do on her cellphone Liked to go to the purchase her favori Staff #2 was substaff #2 "several time creating shopping in the start of programs" or attended to be an attended to be attended to be an attended to be attended att	coming more organized by and researching activities to the local grocery store to the local grocery store to the diet soda and snacks upportive and she spoke with thes a day" about chores, lists and finding things to do g to the mail because she liked participate in "geriatric d day programs in going bowling, to the s or attending parenting by completing online surveys, how to manage her finances budget, but I don't" by to purchase cigarettes from to do it" ople volunteering is a mixture loing community service for who are doing it as a he wanted to be careful with he was around ted that she's "capable of he hadn't researched any eering opportunities er at two well-known and participated in sororities groups prior to living in the get a (part-time) job" because eraction with other human byment) would be very				
						[
Division of He	societyreening like	e I accomplished something	<u> </u>]

STATE FORM

asan a

QE0011

If continuation sheet, 41 of 170

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED	
		MHL092-894	B. WING		· · ·	R-C 04/25/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		, and the second s	
ABSOLL	TE HOME - APEX	109 EVE	NING STAR DI	RIVE			
	· · · · · · · · · · · · · · · · · · ·	APEX, N	C 27502				
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From pa	ige 42	V 112				
	 anything about service - Didn't assist cli Didn't prepian a client #4 Didn't have prepian a client #4 	gress notes or document vices provided for client #4 ent #4 with monthly budgeting activities or play games with planned activities, but she and noe parties" in the facility and ed sometimes					
	and the cause of cli she needed to do ir - The QP spoke to and encouraging cli activities and progra 3/15/25 - She tried to spe	her on client #4's diagnosis ient #4's diagnosis and what					
	 Haven't seen cl goals and strategies Didn't know what client #4's goals Didn't know she #4 with budgeting h 						
	[QP] that did the but - Didn't know she client #4 to prep me sometimes come do there is something a	s [RN/Administrator/Owner] or dget" was supposed encourage vals, "but [client #4] will own (downstairs) and ask if she can help with (in the ly has her own snacks"					
	 Didn't know she #4 with educational, skills She spoke with the community, "but 	was supposed to assist client social or independent living client #4 about going out in she (client #4) refuses" didn't want to participate in					

STATE FORM

QE0Q11

If continuation sheet 43 of 170

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		E SURVEY PLETED
		MHL092-894	B. WING		1	R-C 25/2025
AME OF f	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
REOLU	TE HOME - APEX	109 EVE	NING STAR D	RIVE		
			C 27502			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLE
V 112	Continued From pa	ige 44	V 112	e		
	outbursts					
		nt on any of client #4's goals				1
		·				
	Interview on 3/13/2	5 the Crisis Intervention Team				
ł	With the local Police	Department (PD) reported:				
	response to mental	e PD to help reduce police				
1	 Was called out 	to the facility weekly and				
	some of the calls w	ere from client #4 reporting				
	that staff weren't ac	ministering her medication or				
	not having food in t	he facility				
·	Interview - Alton					
	Interview on 3/26/2	b the QP reported:				
1	until the last week o	I leave from October 11, 2024 of January 2025 and the				
	RN/Administrator/O	wher assumed some of her	1			
	duties while she wa	s done				
	- Was still able to	perform some QP duties by				Ì
	phone during her m	edical leave				
	 Was "still trying 	to catch up from being out"				
		strator/Owner oversaw the				1 1
	operations at the fa	strator/Owner went to the				
1	facility "every two w					
	 "I thought to my 	self, she sure does over there]			
	a lot. Especially after	r staff #1 started"				
	 Was responsibl 	e for developing the clients'				
		she developed client #4's				ļ
	treatment plan	n fan tumimin a at 18 st				i
	 vvas responsibil clients' treatment pla 	e for training staff on the				
		entire plan to the staff, but I				
	go over the clients'	goals and highlighted points"				
	in the treatment plar	าธ]			1
		f on client #4's needs and				
	client #4's "confusio	n due to her diagnosis"				
1	- I CONT KNOW W	y staff say they don't know				
	about [client #4's] tro 	eatment plan" osed to engage the clients in				i I
	various activities and	veen in engage the clients IN	1			ļ

STATE FORM

QE0011

If continuation sheet 45 of 170

	MDER OR SUPPLIER	MHL092-894	B. WING		1 1	
ABSOLUTE			1			≀-C <u>25/20</u> 25
(X4) ID PREFIX	HOME - APEX	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX		109 EVEI APEX, NO	NING STAR DI C 27502	RIVE		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
V 112 Co	ontinued From pa	ge 46	V 112			
Ja - sy did go - - or les ov - (fa tol thi - co - ref sh - sp ref - no - pro sel -	hen she visited the inuary 2025 and P Spoke with clief imptoms" she was dn't report any iss bod" Didn't documen Didn't documen Didn't meet with December 2024 ave and "[RN/Administra actility) frequently d me that she spo ings was going in Client #4 didn't she spoke with didn't she she recently lea mpleting online si She spoke with habilitation in Jam e didn't want to Don't know if the oke with client #4 habilitation or volu Was responsible tes, but didn't do Her job descript ogress notes for " rvices," but clients rvices" in the facil The RN/Administ the rabout her n	At #4 and "inquired about s experiencing, but client #4 ues and said "she was doing at the meetings with client #4 a client #4 in November 2024 due to her being on medical ninistrator/Owner] was taking was out" ator/Owner] was out there .[RN/Administrator/Owner] oke with [client #4] about how the facility" budget her money because thare money information with dent with her money" arned that client #4 was urveys to earn income client #4 about vocational uary 2025 and client #4 said e RN/Administrator/Owner about vocational unteering e for writing clients' progress them ion required her to document clients that get enhanced a didn't receive "enhanced				
	opped because "n ogress notes or de	o one ever asks for the				

QE0011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-894		ECONSTRUCTION	ГСОМ	E SURVEY IPLETED 2-C 26/2025
AME OF PROVIDER OR SUPP	ER STREET A	DDRESS, CITY, S			LUILULU
		NING STAR D	-		
BSOLUTE HOME - APE		IC 27502			
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
progress notes up" with her wo medical leaveFinding B: Exar develop and im excessive use of Example 1: Review on 3/26 11/17/24 reveal - Client #4 car refused to admit completed her of attempt suicide, would retaliate i #4 was involuntReview on 4/10 dated 11/18/24 - "The PT (par of) of worries ar the group home medicine is beind complete her of back into the group by the staff. EM speech, along with movements"Review on 3/14, Note dated 11/1 - "[Client #4], presenting to em home altercation medications are	sly spoke to the QP about writing but "she (QP) struggling to catch k since she returned from aples of how the facility's failure to lement to address client #4's f emergency services. 25 of a police report dated dd: led 911 and reported FS #4 hister her medication unless she hores and she threatened to Client #4 also reported the staff they knew she called 911. Client writy committed (IVC) 25 of client #4's EMS report evealed: tient) (client #4) C/O (complained d believes she is been bullied by staff. The PT reported her g withheld from her if fails to Dres. The PT believes if she goes up home she will be hurt or killed is notes the PT has erratic th repetitive and purposeless 25 of client #4's ED Provider				

STATE FORM

8699

QE0011

If continuation sheet 49 of 170

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COM	e survey Pleted	
		MHL092-894	8. WING			R-C 04/25/2025	
ame of f	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, S	TATE, ZIP CODE			
BSOLU	TE HOME - APEX	109 EVEN APEX, NC	IING STAR DI 27602	RIVE			
(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	TON SHOULD BE	(X5) COMPLE DATE	
V 112	Continued From pa	ge 50	V 112				
	1/14/25 at 3:47pm f - "Erratic residen resident. Caller staff Caller saying the re [Client #1] last know says [client #1] is 'c caregiver is there b room. Caregivers ro downstairsno thre roommates there no and Ms. [client #4] s Example 5: Review on 3/12/25 of 1/14/25 at 7:01pm r - "B/F (black fem skin- can hear her y that caregive (staff) female is arguing in the female said if st do was come down OFC (officer) to lool see that's there is n in the background s 'R******d'states the and doesn't feed the concerned that she the police[RN/Adm of funds for the resim-	tcaller (client #4) is a tes she does not know where Caller in upstairs bedroom , isidents name is [Client #1] who be down stairscaller razy'Now caller states ut does not come out of her bom is right by the door bats made, talked to othing was heard, [client #1] separated" of a police report dated evealed: ale) (Former Staff #3) light rellingcaller (client #4) states hasn't fed them in 3 days - the backgroundcaller states be wanted food all she has to stairs and ask for itwants k inside the refrigerator and othing to eat thereFemale is					

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED	
	971 - ME 967 93 199 96 7 7 97 1 9		A. BUILDING:		COM	FLEIEU	
		MHL092-894	B. WING			R-C 04/25/2025	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BSOLU	TE HOME - APEX		NING STAR DI	RIVE			
		APEX, N	C 27502	····			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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	(XS) COMPLET DATE	
V 112	Continued From pa	ige 52	V 112				
	consuming alcohol - Client #4 becar she refused to give outside of the scher - Client #4 "threa face, I reassured he she said 'you better called 911" - Client #4 kept s (medication) to her - The police arriv something about he - The EMS came medication could "n alcohol" Interview on 3/13/25 - Was unaware of calls to the police un - The officer that 3/12/25 talked to cli nuisance with the ref Interview on 3/26/25 - Was unaware of placed between Oct - Was unaware of placed between Oct - Was unaware of 11/18/24 - Found out about when the facility's pl about physician order - The RN/Adminis any problems" with a	ne aggressive with her when client #4 her medication duled time ifened me and got up in my er that she had her meds, but give me my meds' and she eaving "I'm supposed to give it four times a day" red and "they had to say er (client #4) being aggressive" and advised that client #4's nakes her breath smell like 5 the QP reported: client #4 had made multiple ntil last night responded to the facility on ent #4 about "being a opeated (911) calls" 5 the QP reported: of the 911 calls that were tober 2024 and January 2025 lient #4 was hospitalized on th client #4's hospitalized on th client #4's hospitalized on th client #4's hospitalized on any of the clients in the facility major incidents in the facility major incidents in the facility					
	(facility) that I'm awa elopement (2/20/25)	are of until the (client #4)					
	Interviews on 4/1/25 RN/Administrator/Ov atth Service Regulation					 	

889\$

QE0011

If continuation sheet 53 of 170

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		R-C	
		MHL092-894	1		04/	25/2025
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S			
ABSOLU	TE HOME - APEX		NING STAR DI C 27502	RIVE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	i aı	PROVIDER'S PLAN OF		(X6)
PREFIX TAQ	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET
V 112	Continued From p	age 54	V 112			
	know, I don't reme					
		of the 11/30/24 and 1/10/25				
	incidents	oot the woo colling the patients				
	the facility	ent #4 was calling the police to				
		olice contacting her on 1/14/25				
	about client #4's al	llegation of not having food in				
	the facility					
1	 She spoke with they (alignets) had fit 	h FS #3 and FS #3 said "what or breakfast, lunch and dinner"				
	- "She (client #4) chose not to eat because she				
		and she wasn't hungry"				
	- She spoke with	h client #4 and client #4 said				
	"you can come and	I see," so she went to the				
		as food in the house				
		y issues with the facility not d because she bought				
		o weeks, so the facility didn't				
	run out of food					
	- The second 91	1 call on 1/14/25 incident was				
	due to client #4 and	d client #1 arguing				
1		elved calls "about [client #4]				
Ĩ	and [client #1] yellin	ng back and forth ne way [client #4] was yelling,"				
	in February 2025, I	but she couldn't recall the exact				
	date	······································				
-	Finding C: Example	es of how the facility's failed to				
	develop goals and	strategies to address client #4				
	eloping from the fa	ciiity.				
	Example 1:	af a stall-source to to to t				
	Keview on 3/26/25 11/8/24 revealed:	of a police report dated				ļ
		n // [client #4], W/F (white				
	female)L/S (last s	seen) 30 min (minutes) ago,				1
	cognitive impairme	ntscaller has spoken to her				
	(client #4) on the pl	none and she's upsetcaller				
	(STAIT #2) SOOS her ! stay with hor write -	walking up the street now, will				1
	stay with her until o alth Service Regulation	fficer gets on sceneno				1

Division of Health Service Regulation STATE FORM

8899

QE0011

If continuation sheet 55 of 170

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		Сом		
		MHL092-894	B. WING	B. WING		R-C 04/25/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
ABSOLU	TE HOME - APEX	109 EVE APEX, N	NING STAR DI C 27502	RIVE			
(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 T DEFICIENC'	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From pa	age 56	V 112	Contractor of Franciski Market			
	(5:00pm) and 1800 track but were met) (6:00pm)K-9 attempted to with negative results"					
	2/26/25 revealed;	of a police report dated					
	[unknown male]lo city]Have been di amount of alcohol o	Evening Star on Thursday					
	revealed:	f a police report dated 3/15/25 liked outto get alcohol, left					
	approx (approxima (possibly) near [loc (multiple) call hx (h	tely) 20 minutes agoPoss al grocery store]multi istory) in ref (reference) #4)on foot[local grocery					
	store] clearedligh ago to purchase all be walking back fro	tly at loc (location) 20-30 mins schol, left on footsubj should m [local grocery store] stated					
	check area enroute store]poss subj w	out to get a soda', adv units to back from [local grocery alking near daycarebringing esidence)(facility)"					
	Example 5: Review on 4/10/25 Improvement Syste	of an Incident Response m dated 4/6/25 revealed:					
	 "Date of Incider 	nt 4/3/25At approximately client (client #4) left the facility					
	(RN/Administrator/C made the report to next morning at app	Owner) was contacted and [local PD]Client returned the proximately 11:30 a.m. and					
	informed the staff a been out with her m	nd administrator that she had					

STATE FORM

8899

QE0011

If continuation sheet 57 of 170

	T OF DEFICIENCIES	egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
IND PLAN	OF CORRECTION	IDCN HEIWITIDIK NUMBER	A. BUILDING:		a	-C
		MHL092-894	8. WING	B. WING		25/2025
NAME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
BEALU		109 EVE	NING STAR DI	RIVE		
ABOULU	TE HOME - APEX	APEX, N	C 27502			
(X4) ID PREFIX TAQ	(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 DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 112	Continued From pa	age 58	V 112			
	here (facility)" - Left the facility she returned at 5a - "Walked out th in client #1 and #4 the store and he pi - Staff #1 was in don't think she (sta - Her and the m neighboring city, al she was gone Interview on 4/11/2 - Met up with an she couldn't recall - "I just wanted fa - Couldn't recall - Recalled she " (medication) pass" - Couldn't recall the facility, but all the functioning alarms - Staff #1 was in she had to sneak a - Walked to the man picked her up - She and the m couldn't recall whe - She "probably" - The man drop grocery store the n walked back to fac - Belleved she n before her morning administered - Don't recall the	around 11pm on 2/20/25 and m on 2/21/25 be back door (exit door located shared bedroom), walked to icked me up" in the facility when she left, but " aff #1) know I left out" an went to a hotel in a and she consumed alcohol while 25 client #4 reported: "old boyfriend (4/3/25)," but when to hook up (have sex)" what time she left the facility snuck away at nightafter me " which door she used to leave he facility's exit doors had to the facility when she left, and around her local grocery store and the ban went to a hotel, but she re the hotel was located " had wine while she was gone ped her back off at the local lext morning (4/4/25) and she	d			
		25 client #5 reported: es without permissionleaves				

STATE FORM

6899

ATEMEN	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	· ·	CONSTRUCTION	(X3) DATE COMP	SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	- 79K 199			
		MHL092-894	B. WING			R-C 04/25/2025	
AME OF P	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	ATE, ZIP CODE			
			ING STAR DF				
BSOLU	TE HOME - APEX	APEX, NC	27502	Wine			
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From p	age 60	V 112				
	time"	rom their bedrooms "all the					
	2/20/25	when client #4 left the facility on ng client #4 on the balcony					
	smoking that day,	but she couldn't recall the time ant #4 for dinner around 4pm or					
	5pm and client #3	told her that client #4 didn't					
	- Knew client #4 (client #4) doesn't	had a snack earlier and "she like to eat a lot"					
	bedroom to see w	to client #3 and #4's shared hy client #4 didn't want to eat					
	- She later repo	lient #4 wasn't there rted that she didn't immediately nt #3 and #4's shared bedroom				Ì	
	to check on client						
	because the room	mate (client #3) said she was					
	medications and c	ent #4 down for her 8pm lient #4 didn't come downstairs					
		RN/Administrator/Owner when lient #4 wasn't in the facility					
	- The RN/Admi	nistrator/Owner called 911 and y to search for client #4					
	 Never saw ald The "lady (FS) 	ohol in the facility #3) who left said she smelled					
		hol once when she (client #4)					
	brought her back	saving the facilitythe police (to the facility)"					
		25 staff #1 reported: 4 was leaving the facility to go to					
	the store, but she the facility	never witnessed client #4 leave					
	I - "The clients d leaves for the stor	on't tell me when [client #4] re"				:	

STATE FORM

6699

QE0011

If continuation sheet 61 of 170

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY	
	OF CORRECTION	ELESCIENT DE STAFFE ESSERTE EN LE LE DESSERTE SE	A. BUILDING:			-C	
		MHL092-894	B. WING	B. WING		04/25/2025	
NAME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
ABSOLU	TE HOME - APEX		NING STAR DI C 27502	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From pa	age 62	V 112				
	 Clients stoppenight Believed client Believed client Believed client door, but she didn' Interview on 4/16/2 She checked of "Most of the tir outside" Didn't know ab #4 between 8am a Interview on 3/18/2 The RN/Admir on 2/21/25 to work she didn't arrive ur Was informed arrived to the facilitiener about client #4 they spoke on 2/21 "That's the first drinking and acting Client #4 left th on 3/16/25 "The alarm we go out the back (th shared bedroom) said she was going She called the the RN/Administrat 911 	25 staff #2 reported: istrator/Owner contacted her in the facility on 3/14/25, but still 3/15/25 about client #4 when she ty on 3/15/25 istrator/Owner didn't inform 's increased behaviors when i/25 t time I heard about [client #4] out" to facility through the front doo nt off, so she (client #4) didn't e exit door in client #3 and #4't I tried to stop her, and she to buy a beer" RN/Administrator/Owner and tor/Owner instructed her to call e came to the facility and client	T				
	Interview on 4/12/2	5 staff #2 reported: ient #4 all the time					

STATE FORM

\$**#**\$\$

QE0011

If continuation sheet 63 of 170

TATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING: _			
		MHL092-894	B, WING		R-C 04/25/2025	
		1				
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST NING STAR DI			
BSOLU	TE HOME - APEX		C 27502			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	TION SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE CY)	
V 112	Continued From pa	age 64	V 112			;
	January 2025					
	- Never worked	in the facility prior to 1/22/25				
	- Hadn't seen al	cohol or anyone intoxicated in				
	the facility					
	- No one eloped	from the facility				
	Interview on 3/17/2	25 client #4's private agency				
	guardian reported:					
	- Client #4 was '	"brilliant and college educated	41			1
	but she had "alcoh					
	dementiaWernic	ke Korsakoff"				
1	- Client #4 used	to "live independently" until	.			
	she was hospitaliz	ed because she "couldn't ever)			
	think for months"	ere at a faith and also the mouth				
		aks alcohol" and she "doesn't				
	know how to fix it"	ed from the facility and "went				
	with a man" on 2/2					
	"She (client #4) was returned by the time I	**			
	was about to do a	missing person's report"				
	- Client #4 didn'	t sustain any injuries during th	8			
	elopement on 2/20					
	- Was aware of	the exit door in client #4's				
		wasn't concerned with her	***			
		through the exit door because				
	eloping wasn't a p	roblem	***			
	- "[Client #4] wa	sn't that type to leave out and				
		.Every time I talked to her she				
	was doing good"					
		25 client #4's private agency				4
	guardian reported					
		ohol use in the facility "just				
	started around Jai		****			*
	- FS #3 called t	d client #4 had been "walking				÷
		y)" and she found alcohol in				1
		t #3's shared bedroom				-
		d "it (client #4 eloping on	Active and Active			-
		e first time" and client #4's "fire	st			
1.1	tealth Service Regulation		- · /	<u> </u>		-

STATE FORM

.

STATEMENT OF CERTECTION (X1) PROVIDER SUPPLICAL DENTRIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING: (X3) DATE SURVEY A BULDING: AND PLAN OF CORRECTION MHL092-894 (X) MARE SURVEY (X2) DATE SURVEY MALE OF PROVIDER OR SUPPLIER STREET ADRESS, CITY, STATE JP CODE (A225/2025) ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NC 27502 (A225/2026) OD ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECUTOP OR INS DIDENTIFYING INFORMATION) (D) PREFX (EACH CORRECTION TAG (CACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION TAG (CACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION TAG (CACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION TAG (CACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (CACH AT WARKING CORRECTION (CACH AT WARKING CACH AT WARKING CORRECTION (CACH AT WARKING CACH AT WARKING CORRECTION (CACH AT WARKING CACH AT WARKING CACH (CACH AT WARKING WARKING WARKING THE FACILITY) (CACH AT WARKING CACH AT WARKING WARKING WARKING (CACH AT WARKING WARKING WARKING WARKING WARKING WARKING (CACH AT WARKING WARKI	Division	of Health Service Re	egulation				
AND PLAN OF CORRECTION DEMTRIFICATION NUMBER: A BUILDING. Commentation NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE R-C ABSOLUTE HOME - APEX APEX, NC 27502 APEX, NC 27502 ADD SUMARY STATEMENT OF DEFICIENCIES PRCPX, NC 27502 PRCPX SUMARY STATEMENT OF DEFICIENCIES PRCPX, NC 27502 PRCPX SUMARY STATEMENT OF DEFICIENCIES PRCPX, NC 27502 PRCPX SUMARY STATEMENT OF DEFICIENCIES PRCPX TAG SUMARY STATEMENT OF DEFICIENCIES PRCPX Recalled instructing the staff to call 911, but she couldn't recall 11 the staff solk about seeing client #4 waking down the street V 112 V 112 Continued From page 66 V 112 V 112 Continued From page 66 V 112 - Recalled on 11/11/24 client #4 sold she was taking a wakin, 'but client #4 sold she was taking a wakin, 'but client #4 sold and was used tetting her (client #4) was leaving the facility around 11/11/24 because she 'pay them (client) for call the police" Tak to foll throw client #4 was inaware [client #4] was leaving the house" - The take to foll #14 was unaware [client #4] Take to call me as 0 can takk to the police" - Take to [client #4] the time and [client #1] Take to [client #4] - Thak to [client #4] Take to [client #4] - Take to [client #4] </td <td></td> <td></td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>(X2) MULTIPLE</td> <td>CONSTRUCTION</td> <td></td> <td></td>			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
MHL092-694 B. WING 04/25/2025 NAME OF PROVIDER OR BUPFLIER STREET ADDR8S, CITY, STATE, 2/P CODE ID SEVENING STAR DRIVE ABSOLUTE HOME - APEX ID SEVENING STAR DRIVE APEX, NC 27502 OVAID PREERK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) COMPTEE (EACH DEFICIENCY) V 112 Continued From page 66 V 112 ID PREERK PREERK PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) Comptee (EACH DEFICIENCY) V 112 Continued From page 66 V 112 ID PREERK PREERK PROVIDER'S PLAN OF CORRECTION (EACH TA'S HAWAING down the street PROVIDER'S PLAN OF CORRECTION (EACH TA'S HAWAING down the street PLAN OF CORRECTION (IT A NOW WICH STREET ADDR85 (IT A'S HAWAING down the street PLAN OF CORRECTION (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask was lask was lask tetting her (Cleart #A) washave aptience' because she was 'ThinKing [client #A'] (A'S HA CLEA			IDENTIFICATION NUMBER:	A. BUILDING:		GOMPL	E ED
MHL092-694 B. WING 04/25/2025 NAME OF PROVIDER OR BUPFLIER STREET ADDR8S, CITY, STATE, 2/P CODE ID SEVENING STAR DRIVE ABSOLUTE HOME - APEX ID SEVENING STAR DRIVE APEX, NC 27502 OVAID PREERK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BP FULL PREERK ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) COMPTEE (EACH DEFICIENCY) V 112 Continued From page 66 V 112 ID PREERK PREERK PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) Comptee (EACH DEFICIENCY) V 112 Continued From page 66 V 112 ID PREERK PREERK PROVIDER'S PLAN OF CORRECTION (EACH TA'S HAWAING down the street PROVIDER'S PLAN OF CORRECTION (EACH TA'S HAWAING down the street PLAN OF CORRECTION (IT A NOW WICH STREET ADDR85 (IT A'S HAWAING down the street PLAN OF CORRECTION (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask tetting her (Cleart #A) lask was lask was lask was lask was lask tetting her (Cleart #A) washave aptience' because she was 'ThinKing [client #A'] (A'S HA CLEA					······································		n.
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE ABSOLUTE HOME - APEX 199 EVENING STAR DRIVE APEX, NC 27502 PROVIDER PLAN OF CORRECTION PREDUXTORY OR IS DENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION PREDUXTORY OR IS DENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION PREDUXTORY OR IS DENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION V112 Continued From page 66 V112 Continued From page 66 V112 Recalled instructing the staff spoke about seeing client #4 walking down the street Street #4 from page 66 Recalled instructing the staff spoke about seeing client #4 walking down the street Street #4 from page 66 Recalled instructing the street V112 Precalled instructing the street Street #2 from page 66 Recalled that she went to the facility around 11/11/24 because she "bay three (client #4 "said she was taking a walk," but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "bay three walk was leaving the facility "Ident Know which staff was just letting her (client #4) leave the house" Big bold with client #4 and the tacility "Ident Know which staff was usaware [client #2] No for Client #4] Tak to [client #4] She spoke with client #4 and the the facility 1 Lock to fill #4] She spoke with client #4 and the the facility 1				R WING			
109 EVENING STAR DRIVE APEX, NC 27502 PROMDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSTREEMENDED TO THE PRECEDED BY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY AND AND ADD ADD ADD ADD ADD ADD ADD ADD			MHL092-894			04/21	0/2020
109 EVENING STAR DRIVE APEX, NC 27502 PROMDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSTREEMENDED TO THE PRECEDED BY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREMIX CALCORRECTION (EACH DEFICIENCY AND AND ADD ADD ADD ADD ADD ADD ADD ADD		ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ABSOLUTE HOME - APEX APEX, NC 27502 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LISC IDENTIFING INFORMATION) ID PREFIX TAG D PREFIX (EACH DEFICIENCY) D PREFIX TAG D PREFIX (EACH DEFICIENCY) C PREFIX TAG D PREFIX (EACH DEFICIENCY) C PREFIX TAG D PREFIX (EACH DEFICIENCY) C PREFIX (EACH DEFICIENCY) C PREFIX TAG D PREFIX (EACH DEFICIENCY) C PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) C PREFIX (EACH DEFICIENCY) C PREFIX (EACH DEFICIENCY) C PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) D PREFIX (EACH DEFICIENCY) D PREFIX (EACH DE				ING STAR DE	RIVE		
Oct ID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES BOTHORS: CALL OF THE APPROPRIATE BOTHORS: CALL OF THE APPROPRIATE BOTHORS: CALL OF THE APPROPRIATE DEFICIENCY DEFICIENCY PROVINCES CALL OF CALL OF THE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CONFICTE DATE V 112 Continued From page 66 V 112 V 112 Continued From page 66 V 112 - Recalled instructing the staff spoke about seeing client #4 walking down the street - Recalled of 11/11/24 client #4 "said she was taking a walk." but client #4 didn't have approved unsupervised time - Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month - <td< td=""><td>ABSOLU</td><td>TE HOME - APEX</td><td></td><td></td><td></td><td></td><td></td></td<>	ABSOLU	TE HOME - APEX					
(b) Trace The precency with the precence by Full regimer to the appropriate to the approprise to the approprise to the appropriate to the appropriate to the			and a second and a second and a second	- 61 - 7			(75)
PHETA REGULATORY OR LSC IDENTIFYING INFORMATION) Tag CROSS-REFERENCED TO THE APPROPRIATE DATE V 112 Continued From page 66 V 112	(X4) ID	SUMMARY STA			FACH CORRECTIVE ACTION SHOL	ILD BE	COMPLETE
No DEFICIENCY) V 112 Continued From page 66 V 112 - Recalled instructing the staff to call 911, but she couldn't recall if the staff spoke about seeing client #4 walking awalk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was taking a walk," but client #4 siadi she was taking a walk, "but client #4 siadi she was testing her (client #1) leave the house" - Dich't know client #4 was leaving the facility "Kke that" and "11 did, I toti them (staff) to call the police" - "Every time the police came (to the facility) I toid staff to call me so I can talk to the police" - "Takin to [client #4] all the time and [client #1]" - She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4] to have patience" because she was "thinking [client #1]" and "she (client #4] wasn't able to hande [client #1]" - On 2/20/25, staff #1 called her and reported client #4 missing - She want to the facility and drove around the area looking for client #4 - She called ther and reported client #4		EACH DEFICIENC	SCIDENTIEVING INFORMATION	(CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
 Recalled instructing the staff to call 911, but she couldn't recall if the staff spoke about seeing client #4 walking down the street Recalled on 11/11/2 client #4 didn't have approved unsupervised time Recalled on 11/11/2 client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "It don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" That is to be client #44 on the phone and in period "staff was round [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4]" She spoke with client #4 on the phone and in person "anytime the staff reported "stuese with [client #4] if to have patience" Decause she was "thinking [client #1] was really getting to [client #4]" On 2/20/25, staff #1 called her and reported client #1]" On 2/20/25, staff #1 called her and reported client #4] She work to the facility and drove around the area looking for client #4 She want sable to the police, but she didn't tell the police that client #4 	IAG				DEFICIENCY)	1	
 Recalled instructing the staff to call 911, but she couldn't recall if the staff spoke about seeing client #4 walking down the street Recalled on 11/11/2 client #4 didn't have approved unsupervised time Recalled on 11/11/2 client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "It don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" That is to be client #44 and the time and [client #4] always expressed her issues is around [client #4] She spoke with client #44 to the police" She "spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 issues with [client #4]" She spoke with client #44 was leaving the facility issues with [client #4]" She spoke with spoke of [client #1]" and "she (client #4]" She want to be to hadle [client #1]" On 2/20/25, staff #1 called her and reported client #4" She want to the facility and drove around the area looking for client #4 She want to the facility and drove around the area looking for client #4 She called telling the police that client #4 							
 she couldn't recall if the staff spoke about seeing client #4 walking down the street Recalled on 11/11/24 client #4 "said she was taking a walk," but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was teaving the house" Didn't know which staff was just letting her (client #4) leave the house" Didn't know which staff was leaving the facility "like that" and "if I dd, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] She spoke with client #4 to he poince and in person "anytime the staff reported issues with [client #4] to have patience" because she was "thinking [client #1]" On 2/20/25, staff #1 called her and reported client #1" On 2/20/25, staff #1 called her and reported client #4" She wont to the facility and drove around the area looking for client #4 She cole and police, the the facility "iregularty" Resalled and spoke to the police, but she didn't tall the police that client #4 	V 112	Continued From pa	age 66	V 112		1	
 she couldn't recall if the staff spoke about seeing client #4 walking down the street Recalled on 11/11/24 client #4 "said she was taking a walk," but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if 1 did, I told them (staff) to call the police" "Every time the police came (to the facility) 1 told staff to call me so 1 can talk to the police" The spoke with client #4] the time and [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] She spoke with client #4 is have patience" because she was "thinking [client #1]" Thought" when client #4 "walked away (from the facility) it was because of [client #1]" On 2/20/25, staff #1 called her and reported client #1" On 2/20/25, staff #1 called her and reported client #4 She could can be client #4 She could can be client #4 The client #4 The client #4 The client #4 She calle and spoke to the police, but she didn't tall the police that client #4 She calle and spoke to the police, but she didn't tall the police that client #4 Resalled talling the police that client #4 left the facility "regularty" 		Decolled instru	oting the staff to call 911 but				
 client #4 walking down the street Recalled on 11/11/24 client #4 fisaid she was taking a walk." but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" "Every time the police came (to the facility) 1 told staff to call me so 1 can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her leaves is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #4] to have patience" because she was "thinking [client #1]" and "client #4] to have patience" She "abid [client #4] to have patience to fice the facility if was table to hendle [client #1]" On 2/20/25, staff #1 called her and reported client #1" She want table to hendle [client #1]" She want able to hendle [client #1]" She want able to hendle [client #1]" And 2/20/25, staff #1 called her and reported client #4 She want to the facility and drove around the area looking for client #4 She want to be the facility and the police, but she didn't tell the police that client #4 left the facility "regulary" 			it the staff spake about spains			İ	
 Recalled on 11/11/24 client #4 "said she was taking a walk." but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know which staff was use aving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #4] and [client #4]" She "told [client #4]" She "told [client #4]" "Thought" was because of [client #1]" On 2/20/25, staff #1 called her and reported client #1]" On 2/20/25, staff #1 called her and reported client #1]" She went to the facility and drove around the area looking for client #4 leat the facility "iregulary" Thought" what client #4 left the facility "iregulary" 		She couldn't recail	in the stall spoke about oboing			ĺ	
 taking a walk." but client #4 didn't have approved unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "fif did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I tak to [client #4] all the time and [client #4]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #4] and [client #4]" She "told [client #4]" She "told [client #4]" She "told [client #4]" She wast table to handle [client #1]" She went to the facility and drove around the area looking for client #4 Ne wast table to handle [client #1]" She went to the facility and drove around the area looking for client #4 left the facility "regulary" Recalled talling the police that client #4 		chent #4 walking u	Will life street #4 Penid abo woo				
 unsupervised time Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her lasues is around [client #4]? She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4] to have patience" because she was "thinking [client #1]" was really getting to [client #4] to have patience" because she was "thinking [client #1]" and "she (client #4] wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 She went to the facility and drove around the areal looking for client #4 called her and reported client #4 She went to the facility and drove around the areal looking for client #4 left the facility "regularly" She went to the facility and drove around the areal looking for client #4 left the facility "regularly" 		- recalled on H	-line at all and hour approved				
 Recalled that she went to the facility around 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "If I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me poloe" "I talk to [client #4] all the time and [client #4]" always expressed her issues is around [client #4]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #4]" She "told [client #4]" She "told [client #4]" Thought" when client #4 'walked away (from the facility it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #1]" She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 		taking a walk, but	client #4 ciun i nave approved				1
 11/11/24 because she "pay them (clients) on the 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" "Every time the police came (to the facility) 1 told staff to call me and [client #4] all the time and [client #4] all the time and [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] always expressed her issues is around [client #4] always expressed her have patience" She spoke with client #4 to have patience because she was "thinking [client #1]" and "she (client #4]" Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4] all che rand reported client #4]" On 2/20/25, staff #1 called her and reported client #4] She went to the facility and drove around the area looking for client #4 left the facility "regulary" She called tolling the police, but she didn't tell the police that client #4 left the facility "regulary" 		unsupervised time	the second to the facility around				
 10th" of every month "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4]" always expressed her issues is around [client #4]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4] to have patience" Thought" when client #4 "walked away (from the facility) it was because of [client #1]" On 2/20/25, staff #1 called her and reported client #4] She wint to the facility and drove around the area looking for client #4] 		- Recalled that s	ne went to the racinty around				1
 "I don't know which staff was just letting her (client #4) leave the house" Then later reported "staff was unaware [client #4] was leaving the house" Dight know client #4 was leaving the facility "like that" and "if 1 did, 1 told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #4] She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #4] and [client #4]" She "told [client #4]" She "told [client #4]" She "told [client #4]" She "told [client #4]" She with client #4 'walked away (from the facility) it was because of [client #1]" and "she (client #4] was leaving to b handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regulary" Recalled telling the police that client #4 		11/11/24 Decause	she pay them (crents) on the				1 1
 (client #4) leave the house" Then later reported "staff was unaware [client #4) was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4] to have patience" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" Thought" when client #4 "walked away (from the facility) it was because of [client #1]" On 2/2/25, staff #1 called her and reported client #4 She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" 							
 Then later reported "staff was unaware [client #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #1]" and "she (client #1]" and "she (client #4]" client #1]" and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 lift the facility "regularly" Recalled telling the police that client #4 							
 #4] was leaving the house" Didn't know client #4 was leaving the facility "like that" and "if1 did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4]" She was "thinking [client #1]" and "she (client #4] was because of [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She was to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 the facility "regularly" 		(client #4) leave th	e nouse" Louise for the former for the second				
 Didn't know client #4 was leaving the facility "like that" and "if I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 Ishe was to the police, but she didn't tell the police that client #4 left the facility "regulary" 							
"like that" and "if I did, I told them (staff) to call the police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" On 2/20/25, staff #1 called her and reported client #4 She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		#4] was leaving the	e nouse"				
 police" "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 Recalled telling the police that client #4 		 Didn't know cli 	ent #4 was leaving the facility				
 "Every time the police came (to the facility) I told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" She went to the facility and drove around the area looking for client #4 She wasn't to the police, but she didn't tell the police that client #4 left the facility "regularly" 			did, I told them (staff) to call the				1
 told staff to call me so I can talk to the police" "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She went to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		police"					
 "I talk to [client #4] all the time and [client #4] always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She was to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 	1	 "Every time the 	e police came (to the facility) I				1
 always expressed her issues is around [client #1]" She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tall the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		told staff to call me	e so I can talk to the police"				
 She spoke with client #4 on the phone and in person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She want to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		- "I talk to [client	t #4] all the time and [client #4]				
person "anytime the staff reported issues with [client #1] and [client #4]" She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		always expressed	her issues is around [client #1]"	1			
[client #1] and [client #4]" - She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" - "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" - On 2/20/25, staff #1 called her and reported client #4 missing - She went to the facility and drove around the area looking for client #4 - She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" - Recalled telling the police that client #4		 She spoke wit 	h client #4 on the phone and in				:
 She "told [client #4] to have patience" because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 							1
 because she was "thinking [client #1] was really getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		[client #1] and [clie	ont #4]"				
 getting to [client #4]" "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		- She "told [clier	nt #4] to have patience"				
 "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		because she was	"thinking [client #1] was really				
 "Thought" when client #4 "walked away (from the facility) it was because of [client #1]" and "she (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		getting to [client #4	4] "				
 (client #4) wasn't able to handle [client #1]" On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		- "Thought" whe	en client #4 "walked away (from				
 On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		the facility) it was I	because of [client #1]" and "she				2 3
 On 2/20/25, staff #1 called her and reported client #4 missing She went to the facility and drove around the area looking for client #4 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 		(client #4) wasn't a	able to handle [client #1]"				
client #4 missing - She went to the facility and drove around the area looking for client #4 - She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" - Recalled telling the police that client #4		- On 2/20/25, st	aff #1 called her and reported				
area looking for client #4 - She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" - Recalled telling the police that client #4		client #4 missing		V A #1			
 She called and spoke to the police, but she didn't tell the police that client #4 left the facility "regularly" Recalled telling the police that client #4 				v			1
didn't tell the police that client #4 left the facility "regularly" - Recalled telling the police that client #4		area looking for cl	ient #4				
"regularly" - Recalled telling the police that client #4		- She called an	d spoke to the police, but she	****			
- Recalled telling the police that client #4			e that client #4 left the facility	*			
- Recalled telling the police that client #4		"regularly"		*****			1
eloped from the facility, but "[staff #1] did mention		- Recalled tellin	g the police that client #4				
	1	eloped from the fa	cility, but "[staff #1] did mention				
she (client #4) left out the house beforeone or		she (client #4) left	out the house before one or	*****			1
two times before"							
	Division of	Health Service Regulation	ň				
This defines an it is a line that the second states	DIMBION OF	Liéanu Pelvice Keâniario	14				

STATE FORM

5899

QE0011

If continuation sheet 67 of 170

Division of Health Service Re	agulation				
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	
				R-	c l
	MHL092-894	B. WING		04/2	5/2025
	OTDEET AD		TATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					
ABSOLUTE HOME - APEX		ING STAR D	RIVE		
	APEX, NO	21602			
	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
			DEFICIENCY)		
V 112 Continued From pa	ide 68	V 112			
	-				
client #4 being volu	intarily committed.				
Observations hoter	een 11:29am and 3:00pm on				
3/12/25 revealed:	zen m.∠zam anu s.vvµn vi				
	itting on her and client #3's				
shared bedroom flo	oor scrubbing a brown stain				
with a brush	-				
	bserved either in her bedroom				
or outside smoking					
	t engaged in any structured				
activities	arten kanatad an tha railing at				
the balcony	arton located on the railing of				
the baloony					
Observation at 11:3	34am on 3/14/25 revealed:				
- A small green c	carton still on the railing of the				
balcony					
	mall green carton located on				
the balcony railing a	as boxed wine				
Paview on 2/12/25	of client #4's ED provider note				
dated 3/13/25 revea	-				
	#4) with a past medical history				
of alcoholism,War	micke's encephalopathy				•
presents escorted t	by [local town] to PD with				
	tion with group home				1
	4) states that she is scared.				
	urrounding around alcohol				
abuse and her not i	btain screening blood				1
	alcohol level of 242. At times				; * 1
	ed with staff Mental health	-			
and wellbeing has e	evaluated the patient and also				1
	oup home individual. States				
	en drinking more becoming				
	irritable and causing more				
	oday (3/13/25) had a physical				
	other individual (client) with the ion of Health Service	****			
)) thereAt this time we				
Division of Health Service Regulation	3 .4	1			1

STATE FORM

8449

QE0011

If continuation sheet 69 of 170

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	COM	E SURVEY PLETED	
	• 14	MHL092-894	B. WING			R-C 04/26/2025	
IAME OF P	ROVIDER OR SUPPLIER	STREETAI	DDRESS, CITY, S	TATE, ZIP CODE			
BSOLU	TE HOME - APEX	109 EVE APEX, N	NING STAR DI C 27502	RIVE			
(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 T DEFICIENC	TON SHOULD BE	(X5) COMPLET DATE	
V 112	 wine" and "[Client # Last night she her and calling her The RN/Admin facility that night to walked downstairs RN/Administrator/C Client #4 threw the balcony There was a w floor fan outside on Client #4 broke that client #4 broke that client #4 broke that client #4 broke that client #4 about no Client #4] about no Client #4 "alwa meds four times a a Last night the " went up there (client #4 bedroom) to look u #4) pushed [RN/Ad her the N-word" "She's (client #4) she don't fight me . want to fightShe someone) but have a The RN/Admin client #4 drinking a FS #3 found bo #4's bed in their sh ago and reported it RN/Administrator/C Witnessed FS 	drunk" (2/25)" client #4 was "drinking (4) got drunk" woke up to client #4 cussing at derogatory names istrator/Owner came to the bring groceries and so she to the kitchen to help the Owner put the groceries up ther bed linen and fan off of hite blanket and white circular the ground in the back yard a her fan and she was upset ged her property me saying they had call from t having meds" ys say she suppose to get her day, but that's false" [RN/Administrator/Owner] nts #3 and #4 shared nder the bed and she (client liministrator/Owner] and called (client drinking wine" act like she want to fight but She act like she a thug and s come close (fighting en't followed through" istrator/Owner knew about lcohol in the facility ottles of alcohol behind client ared bedroom a few months to the Owner #3 call the					
		Owner and "asked her why she [client #4] leaving to buy					

STATE FORM

6899

QE0011

If continuation sheet 71 of 170

TATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			0	
		MHL092-894	HL092-894 B. WING			R-C / 25/2025	
	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
			NING STAR DI				
BSOLU	TE HOME - APEX	APEX, N	IC 27502		AL-80-5010-0-5000-510-0-5		
(X4) ID PREFIX TAG	(FACH 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 HE APPROPRIATE	(X5) COMPLET DATE	
V 112	Continued From pa	nge 72	V 112		<u>,</u>		
	- Client #4 was " was "mostly" down - Later reported	mostly' upstairs and staff #1 stairs in the staff's bedroom she felt safe when client #4 it "she (client #4) just shouldn'	ť				
	on 3/13/24 reveale - Client #4's hair was sturred and st - Client #4's eye eyelids were half s	was disheveled, her speech le smelled of alcohol ls were glossed over and her	4				
	crying - She denied dr police to the facility - Never called the have a reason to c	inking alcohol and calling the / ne police because she didn't all them					
	for interrupting the at her and said "of - Soon afterwar	red the dining room, apologize interview and client #4 smiled n, she's (client #1) fine" ds, the front door to the facility #4 yelled "get the f**k out"	1				
	- The QP entern when client #4 say apologizing	ed through the front door and v the QP she started ately, client #4 started yelling a	ıt				
	- The QP exited stopped crying an - Client #4 then for participating in	the dining room and client #4 d continued with the interview stated she would get in troub the interview and refused to					
	expressed her fea	ed raising her voice while she ir of retaliation from staff for i interview					
	statements toward	le threats and derogatory ds DHSR Surveyor urveyor attempted to redirect m the dining room table, but					

STATE FORM

480g

QE0011

If continuation sheet 73 of 170

SMAR PLAN OF CORRECTION IV/V DENTIFICATION NUMBER: A BUILDING:	Division of	of Health Service Re			CONSTRUCTION	(X3) DATE	SURVEY
Nume of PROVIDER OR SUPPLIER MHL092-894 B. WHG	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• -		COMP	LETED
MHL052-894 B. WHG O4/25/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTV, STATE JP CODE 109 EVENING STAR DRIVE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NO 27502 Overlags SUMMARY STATEMENT OF DESIGENCIES 10 PREVIDERS PLAN OF CORRECTION Comments Overlags Build DEFICIENCIES D PREVIDERS PLAN OF CORRECTION Comments Comments Dott Dott Dott Dott Comments Dott Comments Dott Dott </td <td>MILL FEMIL</td> <td>γκε − ∿ራዮአብን ነት ነቶ‱‰ዎቹ £ን⊮° [¶</td> <td></td> <td></td> <td></td> <td>R</td> <td>-C</td>	MILL FEMIL	γκε − ∿ራዮአብን ነት ነቶ‱‰ዎቹ £ን⊮° [¶				R	-C
Imploy2eday STREET ADDRESS, CITY, STATE, ZP CODE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NC 27502 PROVIDER OF DEPICENCIES reach DEPICIENCY MUST BE PRECEDED BY FULL PACE DEPICIENCY ON LIST BE PRECEDED BY FULL PACE DEPICIENCY ON THE PROPROPRIATE DEFICIENCY D V112 Continued From page 74 V112 V112 Continued From page 74 V112 · The QP stated she was going to the magistrate office to file an IVC for client #4 because she "never seen her (client #4) like this" · At 12:Som the QP instructed staff #1 to call 911 if anything happened and left the facility · At 12:Som client #4 and He were upstains and they started yelling at each other · Client #4 yelling at teath #1 to call other · Client #4 yelling at teath #1 to shut the f*k up1," and the music stopped · Staff #1 went upstairs to intervene and client #4 started yelling at teath #1 to go look at the instructions on the medication · Staff #1 to do client #4 that she was going to call the RN/Administrator/Owner and came back downstains · Client #4 yelling at teath #1 to go look at the instructions on the medication and then started yelling at client #1 again · Client #4 node the following threats: · ''You shut up or you will die and I f****g mean that!'' · '' will beat you to g**** mean on the downstairs ceiling · Client #4 piled and then there were more fould bangs on the downstairs and to do BINSR Surveyor 'they (client #1 ada 41 dh 42) actually			SELUL GAA OD 4	B. WING			
109 EVENING STAR DRIVE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NC 27502 PROVIDERS PLAN OF CORRECTIVE ACTION HOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK PREVIDENCE OF CORRECTIVE ACTION HOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK PREVIDENCE TO THE APPROPRIATE DEFICIENCY V112 Continued From page 74 V 112 V 112 Continued From page 74 V 112 * The QP stated she was going to the magistrate office to file an IVC for client #4 because she "never seen her (client #4) like this" • V 112 V 112 * A 12.47pm the QP instructed staff #1 to call \$11 if anything happened and left the fracility • A 12.47pm the QP instructed staff #1 to call \$11 if anything happened and left the fracility • A 12.47pm the QP instructed staff #1 to call \$11 if anything happened and left the fracility • A 12.47pm the QP instructed staff #1 to call \$11 fanything happened and left the fracility • A 12.47pm the QP instructed staff #1 to call \$12 if anything happened and left the fracility • A 12.47pm the QP instructed staff #1 to call \$13 ff #1 went upstals to infervene and client #4 started yelling at staff #1 to call the RN/Administrator/Owner and came back downstairs • Client #4 tha she was going to call the RN/Administrator/Owner • Client #1 and #4 were yelling at each other again • • Staff #1 to call the RN/Administrator/Owner • Clien							
109 EVENING STAR DRIVE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, INC 27502 (#A) ID SUMMARY EXTEMENT OF DEFICIENCIES, (#A) ID DEFICIENCY MUST BUT REPORTING INFORMATION) IP PROVIDERS PLAN OF CORRECTION (#A) CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY) V 112 Continued From page 74 V 112 Continued From page 74 V 112 - The QP stated she was going to the magistrate office to file an IVC for client #4 because she "newer scene her (client #4) like this" - At 12.50pm clients #1 and #4 were upstairs and they started yelling at each other Client #4 to client #1 you!' - Music began playing - Client #4 to client #4 that she was going to call the RNAdministrator/Owner and came back downstairs - Client #4 told staff #1 to clook at the instructions on the medication and then started yelling at client #1 again - Client #4 told staff #1 to glook at the instructions on the medication/Owner - Client #4 tot to following threats: - "You Shut up or you will die and i f****g mean that" - The music started playing gain - The music started playing gain	NAME OF P	ROVIDER OR SUPPLIER					
IDD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IDD PREFIX IDD PREFIX <thidd PREFIX <thidd PREFIX <thidd< td=""><td></td><td></td><td>109 EVEN</td><td></td><td>RIVE</td><td></td><td></td></thidd<></thidd </thidd 			109 EVEN		RIVE		
CALL SUMMARY SATURATION OF THE CONSTRUCTION OF THE CONSTRUCTION ON SHOULD BE CONTROL TO THE CONSTRUCTION ON SHOULD BE CONSTRUCTION ON LOC DEPENDENT ON LOC DEPENDENT ON THE DEPENDENT OF THE CONSTRUCTION ON SHOULD BE CONSTRUCTION ON LOC DEPENDENT ON LOC DEPENDENT ON LOC DEPENDENT ON LOC DEPENDENT OF THE CONSTRUCTION ON SHOULD BE CONSTRUCTION ON LOC DEPENDENT ON LOC DEPENDENT OF THE CONSTRUCTION ON LOC DEPENDENT OF THE CONSTRUCTION ON LOC DEPENDENT OF THE CONSTRUCTION OF T	ABSOLU	TE HOME - APEX	APEX, NO	27502			///6\
 The QP stated she was going to the magistrate office to file an IVC for client #4 because she "never seen her (client #4) like this" At 12:47pm, the QP instructed staff #1 to call 911 if anything heppened and left the facility At 12:58pm clients #1 and #4 were upstairs and they started yelling at each other Client #4 yelled "I'll k" you!" Music began playing Client #4 yelled "I'll k" because she client #4 to call 911 if anything heppened and left the facility Staff #1 wert upstaits to intervene and client #4 started yelling at staff #1 because she client #4 to call the music stopped Staff #1 wert upstaits to intervene and client #4 started yelling at staff #1 because she client #4 to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: " will the you to g***** death!" " will the you by g***** death!" " will the bet you to g****** death!" The music started playing again The music started playing again Client #4 well did then there were more four bangs on the downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 	PRÉFIX	ZEACH DEFICIÉNC	V MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLETE
 The QP stated she was going to the megistrate office to file an IVC for client #44 because she "never seen her (client #4) like this" At 12:47pm, the QP instructed staff #1 to call 911 if anything happened and left the facility At 12:50pm clients #1 and #4 were upstairs and they started yelling at each other Client #4 yelled "11 kt" you!" Music began playing Client #4 toid client #1 to "shut the f"*k up!," and the music stopped Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 toid client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 toid staff #1 to go look at the instructions on the medication and then started yelling at client #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 node the following threats: " will #***********************************	V 112	Continued From p	age 74	V 112			
<pre>magistrate office to file an IVC for client #4 because she "never seen her (client #4) like this"</pre>							
 because she "never seen her (client #4) like firs" At 12:47pm, the QP instructed staff #1 to call 911 if anything happened and left the facility At 12:58pm clients #1 and #4 were upstains and they started yelling at each other Client #4 yelled "I'll k*1 you!" Music began playing Client #4 told client #1 to "shut the f*k up!," and the music stopped Staff #1 went upstains to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstains Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: " I will extra gain" " " will beat you to g***** n death!" The music started playing gain Client #4 yelled and the there were more loud bangs on the downstairs and on the downstairs calling Client #4 yelled and then there were more loud bangs on the downstairs and hold the DHSR Surveyor "they (client #1 and #4) ecually 		- I ne UP siziec monistrate office to	- The QP stated she was going to the				
 At 12:47pm, the QP instructed staft #1 to Call 911 if anything happened and left the facility At 12:58pm clients #1 and #4 were upstairs and they started yelling at each other Client #4 told client #1 to "shut the f**k up!," Ausic began playing Client #4 told client #1 to "shut the f**k up!," and the music stopped Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Client #4 told staff #1 to go look at the instructions on the medication and then started gain Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" The music attrated playing again Client #1 yelled and then there were more foud bargs on the downstairs ceiling Client #1 yelled and then there were more foud bargs on the downstairs ceiling Client #1 yelled and then there were more foud bargs on the downstairs and told the DHSR Surveyor "they (Clients #1 and #4) actually 		hecause she "nev	er seen her (client #4) like this"				
 911 if anything happened and left the facility At 12:58pm clients #1 and #4 were upstairs and they started yeiling at each other Client #4 yelled 'i'll k*" you!" Music began playing Client #4 toid client #1 to "shut the f**k up!," and the music stopped Staff #1 went upstairs to intervene and client #4 started yeiling at staff #1 because she didn't get her medication Staff #1 toid client #4 toi go look at the instructions on the medication and then started yeiling at client #4 were yelling at each other again Client #4 toid staff #1 to go look at the instructions on the medication and then started yelling at client #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "You shut up or you will die and 1 f*****g mean that" "You shut up or you will die and 1 f*****g mean that" Client #1 yelled and then there were more Client #1 yelled and then there were more Client #4 yelled and then there were more Client #1 yelled and then there were more Client #4 yelled yelling and yeling and yelling and yellin		At 12:47pm, the second seco	he QP instructed staff #1 to call				
 At 12:58pm clients #1 and #4 were upstains and they started yelling at each other Client #4 yelled "11 k**1 you!" Music began playing Client #4 told client #1 to "shut the f**k up!." and the music stopped Staff #1 went upstains to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstains Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Client #1 again Client #1 am #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that" The music started paying again The music started paying again Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #1 yelled and then there were more 		911 if anything hat	opened and left the facility	1			
 Client #4 yelled "I'll k**l you!" Music began playing Client #4 told client #1 to "shut the f**k up!," end the music stopped Staff #1 vent upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Client #4 again Client #4 made the following threats: "I will f****gout" "You shut up or you will die and I f*****g mean that!" "I will beat you to g***** n death!" The music started playing again The music started playing again Client #1 yelled and then there were more loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs adold the DHSR Surveyor "they (clients #1 and #4) actually 		 At 12:58pm cl 	ients #1 and #4 were upstairs				ļ
 Music began playing Client #4 told client #1 to "shut the f**k up!." and the music stopped Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Client #4 nade the following threats: Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "You shut up or you will die and I f*****g mean that!" "You shut up or you will die and I f*****g mean that!" The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs a foll the DHSR Surveyor "they (clients #1 and #4) actually 		and they started y	elling at each other				
 Client #4 fold client #1 to "shut the f**k up!." and the music stopped Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 fold client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f***********************************							
 and the music stopped Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		- NUSIC Degan	client #1 to "shut the f**k up!."				
 Staff #1 went upstairs to intervene and client #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" The music started playing again The music started playing again Client #1 yelled and then there were more downstairs ceiling Client #1 yelled and then there were more foud bangs on the downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		and the music sto	oped				
 #4 started yelling at staff #1 because she didn't get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: " will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" The music started playing again The music started playing again Client #1 welled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		- Staff #1 went	upstairs to intervene and client	Į			
 get her medication Staff #1 told client #4 that she was going to call the RN/Administrator/Owner and came back downstairs Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" The music started playing again The music started playing again Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		#4 started yelling	at staff #1 because she didn't				
call the RN/Administrator/Owner and came back downstairs - Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at clent #1 again - Clients #1 and #4 were yelling at each other again - Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner - Client #4 made the following threats: - "I will f*****g hurt you!" - "You shut up or you will die and I f*****g mean that!" - "I will beat you to g*****n death!" - The music started playing again - The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually	l	det her medication	n				1
downstairs - Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again - Clients #1 and #4 were yelling at each other again - Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner - Client #4 made the following threats: - "I will f*****g hurt you!" - "You shut up or you will die and I f*****g mean that!" - The music started playing again - The music started playing again - The music started playing again - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		- Staff #1 told o	client #4 that she was going to				
 Client #4 told staff #1 to go look at the instructions on the medication and then started yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music started playing again Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #2 randownstairs ceiling Client #1 yelled and told the DHSR Surveyor "they (clients #1 and #4) actually 			ustrator/Owner and came back		B		
instructions on the medication and then started yelling at client #1 again - Clients #1 and #4 were yelling at each other again - Staff #1 came back downstairs after saying she was going to call the RN/AdminIstrator/Owner - Client #4 made the following threats: - "I will f*****g hurt you!" - "You shut up or you will die and I f*****g mean that!" - "I will beat you to g*****n death!" - The music started playing again - Client #1 yelled and then there were more foud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		downstairs	staff #1 to go look at the	1			
 yelling at client #1 again Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		instructions on the	e medication and then started				
 Clients #1 and #4 were yelling at each other again Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		velling at client #1	lagain				
again - Staff #1 came back downstairs after saying she was going to call the RN/Administrator/Owner - Client #4 made the following threats: - "I will f*****g hurt you!" - "You shut up or you will die and I f*****g mean that!" - "I will beat you to g******n death!" - The music started playing again - The music started playing again - The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		- Clients #1 an	d #4 were yelling at each other	•			
 she was going to call the RN/Administrator/Owner Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		again					
 Client #4 made the following threats: "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		- Staff #1 came	e back downstairs after saying	, w			
 "I will f*****g hurt you!" "You shut up or you will die and I f*****g mean that!" "I will beat you to g*****n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		she was going to	call the rollowing threats:	*1			Į
 "You shut up or you will die and I f*****g mean that!" "I will beat you to g***** n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 			hert vol ⁿ				
that!" - "I will beat you to g***** n death!" - The music started playing again - The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		- iwai yu	or you will die and I f*****a mea	n			
 "I will beat you to g*****n death!" The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		that!"					
 The music started playing again The music abruptly stopped and was followed by loud, fast stomping noises heard on the downstairs ceiling Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 		 "I will beat yo 	ou to g*****n death!"				1
by loud, fast stomping noises heard on the downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		 The music st 	arted playing again				
downstairs ceiling - Client #1 yelled and then there were more loud bangs on the downstairs ceiling - Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		- The music al	bruptly stopped and was followe	al			
 Client #1 yelled and then there were more loud bangs on the downstairs ceiling Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually 							-
loud bangs on the downstairs ceiling – Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		downstairs ceilin	g Iad and then there were more				1
- Client #5 ran downstairs and told the DHSR Surveyor "they (clients #1 and #4) actually		- Unerit # 1 yell	e downstairs ceiling				1
Surveyor "they (clients #1 and #4) actually		Client #5 ran	downstairs and told the DHSR				
		Surveyor "they (c	clients #1 and #4) actually				4
		fighting"					
- Staff #1 ran back upstairs and client #4 yelled		- Staff #1 ran	back upstairs and client #4 yelle	d			-
"she (client #1) hit me in the face"				<u> </u>			1

Division of Health Service Regulation STATE FORM

6599

TATEMEN	of Health Service Report of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	R	-C
		MHL092-894	B, WING		04/2	25/2025
	ROVIDER OR SUPPLIER		DRESS, CITY. ST			
		109 EVE	NING STAR DI	RIVE		
ABSOLU	TE HOME - APEX	APEX, N	C 27502			
(X4) ID PREFIX TAG	ZEACH 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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 112	Continued From p	age 76	V 112			
V 112	PLAN OF CORRECTION IDI E OF PROVIDER OR SUPPLIER SOLUTE HOME - APEX BOLUTE HOME - APEX SUMMARY STATEMENT REGULATORY OR LSCIDENCY MUST I REGULATORY OR LSCIDENCY MUST I AG The clients went into client #1 closed her bedro - The clients went into client #1 closed her bedro - She came back down heard "a boom" and the co - She went back upsta coming from her bedroor - Client #4 said client # and she saw a small cut client #4's mouth - Client #4 went to the and client #3's shared be - She was going to cal 911 faster than she could - A Police Officer appr speak with staff #1 abou Interview and observatio client #3 reported: - - Client #1 and [Client #1] and [ent into their bedrooms and er bedroom door ok downstairs and then she nd the clients yelling k upstairs and saw client #4 bedroom client #1 kicked her in the lip nall cut on the top right corner of t to the balcony outside of her ared bedroom and called 911 ig to call 911, but client #4 calle he could er approached and asked to				
	client #3 reported - Client #3 was facility's front doo - "[Client #1] ar until today" - She felt safe it's (client #4's int	l: s sitting in the foyer near the or nd [Client #4] never got physics because "I can handle myself,	1			
	the local Police C - Could smell - Saw a "light but she wasn't su bruise	alcohol on client #4 orange area" on client #4's face are if the discoloration was a	• ,			
	lower right side of the area of the d - She spoke w - Client #4 we voluntary commi - Didn't arrest	vith the RN/Administrator/Owne nt to the local hospital for	r			

Division of Health Service Regulation STATE FORM

QE0011

Division of Health Service Regu TATEMENT OF DEFICIENCIES (X1 ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
ND PLAN	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		MHL092-894	B. WING		1	l-C 25/2025
AME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
DEOLU			NING STAR DI	RIVE		
BSOLU	TE HOME - APEX		C 27502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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	(X5) COMPLET DATE
V 112	Continued From pa	ige 78	V 112			
	facility - Didn't know clie grocery store - Didn't recall FS alcohol use on 1/27 - Staff #1 "never client #4's alcohol to - Staff hadn't rep alcohol daily or eve - "Staff are supp drinking alcohol" - "Normally they level I incidents - "Staff know wh call [QP] when it's - The QP then it's - She heard a kn and the police werv - Client #4 called get her medicine" - Client #4 beca started "cussing at - "She (client #4 think she pushed r - She "looked in shared bedroom) a	reported" her suspicion of use borted client #4 was drinking ery other day losed to tell us when clients an (staff) would tell [QP]" about hat [QP] handlesstaff know to client behaviors" informed her of the reported why they (staff) would not say ent #4's alcohol use /12/25 incident because she g upstairs to the clients' hi" nock on the facility's front door e at the door d 911 and alleged she "didn't me verbally aggressive and cmescreaming in my face" b) got in my face, but I don't me that night (3/12/25)" in the room (client #1 and #4's and saw empty bottles	e		·	
	to the (client #4's) - Was on the pr the QP what she for shared bedroom	bottles, located on a bag next bed" none with the QP and she told ound in client #3 and #4's ar mind that client #4's				

STATE FORM

5239

QE0011

STATEMEN	of Health Service Re tof deficiencies of correction	QUIATION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL092-894	B. WING		R-C 04/25/2025
ABSOLU (X4) ID PREFIX-	(EACH DEFICIENC)	STREET AD 109 EVEN APEX, NC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ING STAR (27502 ID PREFIX	STATE, ZIP CODE DRIVE PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
V 113	Review on 3/12/25 - No documenta outcomes Review on 3/12/25 - Admitted 11/2/ - No documenta outcomes Review on 3/12/25 - Admitted 11/2/ - No documenta outcomes Review on 3/12/25 - Admitted 11/2/ - No documenta outcomes Review on 3/12/25 - No documenta outcomes Review on 3/12/25 - No documenta outcomes Review on 3/12/25 - No documenta	sc IDENTIFYING INFORMATION) age 81 ecified in G.S. 130A-143. et as evidenced by: eview and interview, the facility a complete record for 5 of 5 #4, #5). The findings are: of client #1's record revealed: 107 tion of progress towards goal of client #2's record revealed:	V 113	CROSS-REFERENCED TO THE APPRO DEFICIENCY) V113 Client Records The client records are to be maintained by the facility s The QP has instructed and provided training to the sta how to maintain a record a what is to be included in th record. The newly hired sta be starting during the 2 nd v May and has experience of to maintain a client record Additionally, staff are resp for completing the face sh and inserting them in the o records. The administrator and/or QP will check maintenance of the record during the quarterly QA re QP will resume completing monthly progress notes to	e staff. aff on and hat aff will week of n how consible eets client f
	Attempted review was unsuccessful not in the facility.	admitted 5/24/23 on 3/12/25 of client #4's record because client #4's record was		any progress, lack of progr concerns and inserting the the records on a monthly l	em in
Division of I	lealth Service Regulation	55am on 3/13/25 revealed:	****	QE0011	# continuation sheet 82 of 17

STATE FORM

continuation sheet 82 of 170

Ξ,

Division	of Health Service Re	egulation			1 2 3 00 1	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		MHL092-894	B. WING		R-C 04/25/2025	
UNUE AF		\$	NOCCE CITY 6			
NAME OF	PROVIDER OR SUPPLIER					
ABSOLU	TE HOME - APEX	APEX, NC	ING STAR D			
	CLINING DV CT	TEMENT OF DEFICIENCIES	······	PROVIDER'S PLAN OF CORRECTION	31	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XS) COMPLETE DATE
V 113	Continued From page 83		V 113			
	Interview on 3/27/2 reported: - "Don't docume progress notes - Didn't docume outbursts Interview on 3/28/2 - Was responsib records by ensuring client's face sheet a summaries from m Interview on 3/13/2 - Couldn't find cl a new one by printi stored on her comp - Wasn't sure wf - Client records y locked in the facility Interview on 3/18/2 reported: - Wasn't response records - "I'm not doing a [RN/Administrator/0 responsibility" - Didn't know wh sheets were - Staff were supp records, but she an were responsible for the client records b	5 Former Staff (FS) #4 nt anything" and didn't write nt on any of client #4's goals nt client #4's behavioral 5 FS #4 reported: le for maintaining the clients' g the client record had the and the clients' after-visit edical appointments 5 the QP reported: ient #4's record so she created ng off documents she had buter here client #4's record was were supposed to be kept				
		review was completed in nd it was now time to do				
	another review	nu it was now time to QO				
Division of H	salth Service Regulation		L	~~~~~	1 4/4 Million	

STATE FORM

8899

QE0011

If continuation sheet 84 of 170

Division (of Health Service Re	gulation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
			- 16851C		R-C	
	······································	MHL092-894	B. WING		04/2	5/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
100011		109 EVEN	ING STAR D	RIVE		
ABSOLU	TE HOME - APEX	APEX, NO	27502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 113	Continued From pa	ige 85	V 113	g ng		
	sheets" because "a FL2" - "We will have t sheets)" - She and the Q completing record - Checked the c the clients' docume months - The QP brough it in the client record - She and the Q clients' records on "interrupted" by clie couldn't complete t - Didn't know wh was, but she recall facility during the a - Staff were sup behavioral outburs outbursts were leve	lient records and looked over entation for the last three ht her documentation and filed ds P were supposed to review the 10/30/24, but they were ent #1's behavior and they the review here client #4's original record ed client #4's record in the innual survey in October 2024 posed to document the clients' t because the behavioral et I incidents				
	be documented - Didn't have do behavioral outburs					
	notes in their record - "Talk to [QP] a - The QP assest month, but she's "	bout the progress notes" sed the clients' goals every struggling to catch up" with her				
	This deficiency col This deficiency is (urned from medical leave nstitutes a re-cited deficiency. cross referenced into 10A				 • • • • • • • • • • • • • • • • • • •
	Professionals and (V109) for a Type, within 23 days.	Competencies of Qualified Associate Professionals A1 and must be corrected				
Division of H	lealth Service Regulation	1			Manadimentities	n ehaat 86 of 17

.

110

4 5

PRINTED: 05/12/2025 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROV ND PLAN OF CORRECTION (X1) DENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-894	B. WING		R-C 04/25/2025	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST HING STAR DF 27502		ŧ	
(X4) ID PREFIX - TAG		NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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
V 118	Based on record re failed to administer order of a physicia current for 5 of 5 c findings are: Finding A: Review on 3/12/25 - Admitted 8/30/ - Diagnoses of 3 Disorder-Paranoid Gastroesophageal - Physician order medications: - 3/20/24: - ClearLax Pow ounces (oz) of liqu (Constipation) - 12/8/24: - Amlodipine Be 1 tablet (tab) by m (Hypertension) - 12/19/24: - Oxybutynin 5m (BID) (Bladder Co - 1/16/25: - Melatonin 3ms (Insomnia) * Divalproex So PO BID (Mood) - Benztropine M PO BID (Mood)	et as evidenced by: eview, and interview, the facility r medications on the written n and failed to keep the MAR lients (#1, #2, #3, #4, #5). The of client #1's record revealed: 707 Schizoaffective Bipolar Type and Reflux Disease ars dated for the following der mix 17 grams (gm) in 4-8 fid and drink as needed (PRN) esylate 10 milligrams (mg) take outh (PO) every day		V 118 Medication Require The staff on duty at the tin the survey was retrained of medication administration documentation as well as of necessary reporting and documentation protocols for missed meds by a contractor The incoming staff has been trained on medication documentation and administration previously a an understanding of requirements.	ne of on and on or ed RN.	
	- 2/25/25: - Olanzapine 10 tongue at bedtime	Orng dissolve 1 tab under (Schlzophrenia) 5 of client #1's January and	ur 4	~		

STATEMEN"	of Health Service Ro TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (J WREED	MHL092-894	B. WING		R-C 04/25/2025	
			RESS. CITY, SI	TATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		ING STAR DE			
ABSOLU	TE HOME - APEX	APEX, NC				maaaaa
(X4) ID PREFIX TAG	いたっ べいし やさについた(のもい)	ATEMENT OF DEFICIENCIES IN MJST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LDBE	ば) いでE いでE
V 118	Continued From p	age 89 n 2/28/25 (pm)	V 118	The staff have been traine		
	- Benztropi	ne Mes 2/28/25 (pm)		ordering medications whe		
	- Divalproe	 Divalproex Sod 2/28/25 (pm) 		supply is down to 7 days. 1	This has	
	Intonvinus op 4/16/	25 client #1 reported:		always been the protocol.	The	
	. Wee administ	ered her medications		pharmacy delivers medica	tions	
	- Her medicatio	ions were always in the facility		on a predetermined		
	markan D-			schedule/cycle. At times t	he	
	Finding B: Review on 3/12/2	5 of client #2's record revealed:		medications have to be or		
	- Admitted 11/2	2/20		from other manufacturers		
-	- Diagnosis of	Schizoaffective		may not be available at th		
	Disorder-Paranol	lers dated for the following		it is requested. Therefore,		
	medications:		1	•		
	- 3/22/24:	(non minner (mon) taka 1		ordering the medications	1	
	tab PO every day	1000 microgram (mcg) take 1		the supply is within 7 days	SOT	
	- Vitamin D3 1	000 units (U) take 1 capsule		depleting is the protocol.		
	(cap) PO every d	ay (Supplement)		Medications are to be	•	
	- 7/1/24:	40mg take 1 tab PO at bedtime		administered as ordered I	oya	
	(Cholesterol)	tonia muo i toni toni toni		licensed provider and stat	fare	
	10/14/24:	a construction of the second statement		expected to follow those (orders.	
	- Haldol 2mg t	ake 1 tab PO at bedtime		Documentation of those		
	(Schizophrenia)	.05 mg take 1 tab PO at bedtime		administrations are respo	nsibility	
	(Schizophrenia)			of the staff person on dut	1	
	10/21/24	wder mix 17gm in 4-8 oz of fluid		will be reviewed by the	· · · · · · · · · · · · · · · · · · ·	
	and drink every	MARCE THEY IN A SET IN THE COMMENT OF COMMENT		administrator and/or QP	on a	
					1	
	Review on 3/12/	25 of client #2's January and	•	quarterly basis during QA		
	February 2025 M	2025 MAR revealed the		reviews. Documentation :		
	following dates t	he medications were not	****	ordering protocols will be	,	
	documented as	administered and the box for the		retrained by the contract	ed RN as	
	line or covered v	vith white out:		needed.		
	staff's initials we	re crossed out with a diagonal with white out: x Powder 1/1/25 and 1/2/25		•		

6899

QE0011

1. N. . .

2) 2

ATEMEN	/ision of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
D PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:			
		MHL092-894	B. WING		1	-C 25/20 <u>25</u>
		1				
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST NING STAR DF			
BSOLU	TE HOME - APEX		C 27602			
		TEMENT OF DEFICIENCIES	i ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	CORRECTION	(X5) COMPLETE
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
V 118	Continued From pa	age 90	V 118			1
	(whited out), 1/4/28	5, 1/10/25 (whited out), 1/13/25				ł
	(whited out), 1/15/2	25 (whited out)-1/16/25 and				
		/22/25-1/30/25 (crossed out)				1
	and 1/31/25					
		12 1/24/25 and 1/25/25				
	(crossed out) Vitamin Di	3 1/24/25 and 1/25/25 (crossed	1			
	out)	a star-stard deside transformed for some se	•			
	- Atorvastat	in 1/23/25 and 1/24/25				1
	(crossed out)					
	- Haldol 1/2	3/25 and 1/24/25 (crossed out				
		ne 1/23/25 and 1/24/25				1
	(crossed out)	2005 MAD revealed the				1
	- The February	2025 MAR revealed the ons were not documented as				
	administered:	019 March 1101 Condition 110				1
	- Atorvasta	in 2/28/25				
	- Haldol 2/2					1
	- Risperido	n e 2/28/25				
	Interviews on 3/12	/25 and 4/16/25 with client #2				
	provided limited in	formation because client #2's				
		as difficult to understand. Clien	t			
	#2 reported:	e an e fille a causeline.				1
		ine in the facility overnight nistrator/Owner would come to				1
		minister medicine to help				
		ered her medicine	**			
		getting her medications	****			
	- Her medicatio	ns were always in the facility				-
	Interview on 3/13/	25 client #2 verified that she				*
	and the clients we	re left alone overnight. The				-
	interview was uns	uccessful because client #2		1		•
	was difficult to un	derstand due to her speech				
	pattern and lack c	of pronunciation of her words.				
	Finding C:					5 WINDOW # 444
		25 client #3's Department of				
	Social Services g	uardian revealed:				
	Health Service Regulation					

TATEMEN	of Health Service Re T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		R-C	
		MHL092-894	8. WING		04/25/2025	
AME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		109 EVE	NING STAR DI	RIVE		
ABSOLU	TE HOME - APEX	APEX, N	C 27502			
(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	FION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	age 92	V 118			
	•	1/23/25 (pm) (crossed out),				
	1/24/25 (crossed o	ut) and 1/25/25 (am)(crossed				
	out)	•				
		1/24/25 and 1/25/25 (crossed				:
	out) Mitamin Ré	12 1/24/25 and 1/25/25				
	- Vitamin B12 1/24/25 and 1/25/25 (crossed out)					1
	- Clozapine 1/24/25 and 1/25/25 (am)					Ì
	(crossed out), 1/10)/25-1/31/25 (2pm) and 1/23/25				
	-1/24/25 (crossed					1
	3	1/24/25 and 1/25/25 (crossed				
-	out) - Divaloroex	c Sod 1/23/25 (pm) (crossed				
		sed out) and 1/25/25 (am)				*
	(crossed out)					
	- Olanzapin	e 1/24/25 (crossed out)				
	- Cionazepa	am 1/24/25 (crossed out) ary 2025 MAR revealed the				
	following medication	ons were not documented as				-
	administered:		4			н 1
	- Metformin					
	- Olanzapin					-
	- Cionazepa	am 2/28/25				-
	Interview on 3/12/2	25 client #3 reported:				
	 Was administer 	ered her medicine daily				
	 Only missed h 	er medicine the night of				-
	1/23/25	diants in the facility oversight				
	on 1/23/25	clients in the facility overnight				w vs. *********
		hen FS #5 left the facility				NAVA ANALY
		evening medicine on 1/23/25				
		#5 retrieved the key to the				
		loset from the staff's bedroom 4) said she wasn't going to mis	s			:
	her meds (medici		×			, () mmmm
	- Clients #4 and	#5 administered their own				• #P. 100000
	medicine on 1/23/					1 maaa 1 '
		nistrator/Owner came to the				-
	facility around 9an tealth Service Regulation	n or 10am the morning of	1	<u> </u>	~	

STATE FORM

6699

QE0011

If continuation sheet 93 of 170

TATEMENT	of Health Service R OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		R	SURVEY PLETED
		MHL092-894	B, WING	······································	04/	25/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY. S			
. Dect 12	LE HOME - APEX		ING STAR DI	RIVE		
ABSOLU		APEX, NO	27502		DECTION	(X5)
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	DATE
V 118	Continued From p	age 94	V 118			Ì
	documented as ad staff's initials were line or covered wit - Certavite- (crossed out) - Gabapent 1/23/25-1/24/25 (d (crossed out) - Sertraline - Atorvasta out) and 1/31/25 - Monteluk (crossed out) - Vitamin E out), 1/26/25 and 1/31/25 (crossed - Folic Acid and 1/3/25-1/31/2 - The February following medical administered: - Monteluk - Gabaper - The March M medication was i was administered - Gabaper Interview on 3/12 - Didn't know i facility overnight - "Staff won't g	Antioxidant 1/23/25-1/25/25 tin 1/22/25 (pm) (crossed out), crossed out) and 1/25/25 (am) a 1/23/25-1/25/25 (crossed out) tin 1/23/25-1/25/25 (crossed ast Sod 1/22/25-1/24/25 at 1/23/25-1/25/25 (crossed 1/27/25 (whited out), 1/28- out) a 1/1/25 and 1/2/25 (whited out) 25 / 2025 MAR revealed the tions were not documented as (ast Sod 2/28/25 httin 2/28/25 MAR revealed the following nitialed indicating the medication				
	- Was adminis	stered her medicine daily a night without staff giving me				-
	Interview on 4/16 Health Service Regulat	5/25 client #4 reported:				1

Division of Health Service Regulati STATE FORM

seba

Division	of Health Service Re	gulation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3 5 5		
					R-C	
		MHL092-894	B. WING		04/25/2025	
	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE		
			ING STAR I			
ABSOLU	TE HOME - APEX	APEX, NO				
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL	D BE COMPLE	ΓE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DAL	
V 118	Oppliqued From no		V 118			
V 110		Qe so	VIIO			
	out) - Olanzapine	1/23/25 and 1/24/25 (crossed				
	out) - Olanzapine 1/23/25 and 1/24/25 (crossed out)					
					4 -	
		2025 MAR revealed the				
	administered:	ns were not documented as				
	- Docusate S	Sodium 2/28/25				
	- Trazodone 2/28/25				1	
	- Olanzapine - Olanzapine					
	Contraction of the	a Mat An Wet Am W				
		5 client #5 reported:				
		ered her own medicine red her medicine daily				
		t (clients left alone overnight)				
	has happened"					
	- She later repor	ted the Jwner came to the facility the				
		and administered the clients'	40 - An 2010 - An 201			
	- There wasn't a	staff in the facility when the				
		wher arrived on 1/24/25			*	
	 FS #5 left the c overnight 	lients alone in the facility				
		5 client #5 reported:			4	
	 FS #5 left the c 1/23/25 	lients alone in the facility				
		minister the medicine to the			i	
	clients before she I	eft		}	۰ ۰	
		r evening dose of medicine s) got meds that night		f	1	
	- INO ONE (client) (1/23/25)"	oy you meus unat mymt				
	- Didn't have a n	egative consequence from not				
	receiving her medic					
	 She contacted the morning of 1/24 	the RN/Administrator/Owner			1	
		inistrator/Owner) asked if the				
	ealth Service Regulation		-	<u>՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟՟</u>	*******	
STATE FOR	M		4699	QE0011	f continuation sheet 97 of	170

Division	of Health Service Re	aulation				······
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING;		COMP	LEIED
					R-C	
		MHL092-894	B. WING		04/2	5/2025
			SECCO AITY O	TATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		ING STAR DI			
ABSOLU	TE HOME - APEX	APEX, NO				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT	<u>0N</u>	178	
(X4) ID PREFIX	SUMMARY STA	Y MUST BE PRECEDED BY FULL	id Prefix	(EACH CORRECTIVE ACTION SHOUL	LD BE	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRC	PRIATE	DATE
				DEFICIENCY)		
V 118	Continued From pa	ige 98	V 118			
	•	- istrator/Owner corrected her				
		pr, but she couldn't recall when				
		he clients' medications on				1
		rgot to sign the clients' MARs	ł			
	- FS #3 was at t	he facility when she arrived on				
	2/1/25, not the RN/	Administrator/Owner				
		5 staff #1 reported:				
		ed "one dose" of her				1
		5/25 because the medication				1
	wasn't in the facility	/ n the pharmacy" to deliver				
	client #4's medicat					
		pharmacy for refills "last				
		lied the pharmacy on Thursday				
		/11/25) and Monday (4/14/25)				
	to check on the ref	2 mart				
	 The pharmacy 	was supposed to deliver client				
	#4's medicine on 4	/14/25, "but they didn't"				
	- Instructed to co	ontact the pharmacy a week medications running out to				
	have them refilled	medications running out to				1
		ally signed" client #4's March				ţ
	MAR on 4/15/25 be	ecause she "forgot she (client				
		the facility)" and was at the				1
	hospital	F .				
		supposed to sign the clients'				
	1	ministered the clients'				
	medications					
	Intentiew on 2/10/2	25 and record review of clients				
1		5's January 2025 MARs with				
	FS #5, FS #5 repo					
		aff and she filled in to work at				
	the facility on 1/22/					
	 Filled in to wor 	k at the facility on 1/22/25				1
	- Was the first ti	me she worked at the facility				1
	- Couldn't recall	how long she worked, but she				:
) for a couple of days"				1
L		re written on the clients' MARs				<u>.</u>
Division of H	lealth Service Regulation	•				

STATE FORM

6499

QE0011

If continuation sheet 98 of 170

Division of Health Service Regulation			CONSTRUCTION	(X3) DATE			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMP	COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION RUMPERS	A, BUILDING:		R	.c. l	
						5/2025	
		MHL092-894	B. WING				
	······································		DRESS, CITY, S	TATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		IING STAR DI				
	TE HOME - APEX						
ABSULU		APEX, NO		PROVIDER'S PLAN OF	CORRECTION	(X5)	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX	ICACH CORRECTIVE ACT	TION SHOULD BE	DATE	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	HE APPROPRIA	DATE	
TAG	REGULA: ORI ORI			DEFICIEN			
			V 118				
V 118	Continued From p	age 100	VIIO				
	Interview on 4/16/	25 the QP reported:					
	 Client #4 didn 	't receive her morning dose of					
	Gebenentin on 4/	15/25 because the pharmacy					
	was late delivering	the medicine to the facility				i	
	- Client #4 calle	d 911 when she didn't receive					
	her medication						
	- Staff #1 "faile	d to tell me that [client #4] ran					
	out of medicine"	the second of the second dialog					
	 The pharmac 	y delivered client #4's				1	
	medication the ev	ening of 4/15/25					
	- She contacte	d client #4's private agency		W			
	guardian and the	y both agreed for client #4 to go				1	
	to the nospital to	receive her medication				ł	
	Interviews on 4/1	/25 and 4/2/25 the				1	
	QN/Administrator	/Owner reported:					
	- Staff were re	sponsible for administering the					
	clients' medicatio	ns and documenting the clients	•	8 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			
	MARs						
	- Was respons	ible for checking the clients'					
	medications and	MARs					
	- She's been o	hecking the clients' medications	3			3 1 1	
	and MARs "every	/ week since [staff #1] started					
1	working (1/24/25)"					
	- Her checking	the clients' medications and	* 2000 UNIX * * * * *				
	MAKS "depends	on who's working some staff				8 # 2	
	are good at not n	naking errors[staff #1] is still	****				
	training and need	check the clients' medications	400000				
		meone complained about their				*	
	medication"		P			-	
	- Client #2 wa	sn't administered her Docusate	Hannelike vi			1	
	Sodium because	she had loose stool"					
	- Couldn't rec	all if she or staff contacted clien	t			2 - 1	
	#2's doctor abou	It her having loose bowels				<	
	- FS #3 put th	e dashes on the clients' MARs				********	
	and "she wasn't	supposed to"					
	- "The only tin	ne they (clients) didn't have me	08			**************************************	
		the 23rd (1/23/25)"	<u> </u>				
	Handles Deella	lan					

4449

Division	of Health Service R	egulation						
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
					R-	C		
		MHL092-894	B. WING		04/2	5/2025		
	ROVIDER OR SUPPLIER	στρέετ Δη	T ADDRESS, CITY, STATE, ZIP CODE					
	-ny when va aufflier		ING STAR D					
ABSOLU	TE HOME - APEX	APEX, NO		. 24 m men				
	SI MALARY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION	(X5)		
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	ld be	COMPLETE		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	VAIS		
		۲۵٬۰۰۰ منه مراجع در مربع المراجع			······			
V 118	Continued From pa	age 102	V 118					
	documentiust dr	aw one line across" to						
ł	document an error							
		25 the RN/Administrator/Owner						
	reported:	didn't fill and deliver client #4's						
	 medication to the f 							
		ted the pharmacy a week prior				-		
	to client #4's media	cation running out						
		posed to contact the pharmacy						
	a week prior to the	ir medications running out						
		4 JF 100 F	1400			1		
V 123	27G .0209 (H) Med	dication Requirements	V 123					
	10A NCAC 27G .0	200 MEDICATION						
	REQUIREMENTS	END REFIMENTING		V123 Medication Requirer	Viante			
		rs. Drug administration errors		* TTO INCOURT INCOME	23500 J 1.26			
[and significant adv	erse drug reactions shall be		Medication Training has b	één			
	reported immediate	ely to a physician or		—				
	pnarmacist. An ent	try of the drug administered on shall be properly recorded		conducted and will be upd				
		A client's refusal of a drug		and retrained as needed. /				
	shall be charted.	ત પ ગામકાત્માં દેવે પત્ર કે ગામકા માલ્યા આવે આવે છે. આ પ્રાથમિક જાત છે		medication refusals will be	è.			
	•			reported to the administra	tor/RN			
				and the QP immediately.				
				administrator will inform t				
				prescriber (MD, PA, NP, et	c}			
						-		
		et as evidenced by:						
		eview and interview, the facility						
	failed to immediately report medication errors and refusals to the physician for 2 of 5 clients (#1, #4).		· ·					
	The findings are:	solution $\angle 0$ of a cherry (#1, #4).						
	тто нимайо ага.							
	Finding A:							
		of client #1's record revealed:						
	 Admitted 8/30/ 	07						
Division and be	ealth Service Regulation	Manager and Andrews						

Division of Health Service Regulation STATE FORM

6888

QE0011

continuation sheet. 103 of 170

STATEMEN	ND PLAN OF CORRECTION DENTIFICATION NUMBER:		A. BUILDING: _	CONSTRUCTION	COMP R-	-
		MHL092-894	B. WING		04/2	5/2025
	ROVIDER OR SUPPLIER TE HOME - APEX	109 EVEN APEX, NO	DRESS, CITY, ST HING STAR DR 27502	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	JEACH OFFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	DATE
V 123	Continued From pa - Benztropine M	-	V 123	cont'd		
	 Benztropine Mes 3/8/25-3/12/25 (am and pm) Interview on 3/12/25 client #1 reported: Missed her medication "lately" Didn't want to take her medicine today because she "don't need it" Interview on 4/11/25 the pharmacist reported: Was unaware of client #1's medication refusals in March 2025 Called the facility on 4/10/25 and the facility "verified that they failed to contact me regarding her med (medication) refusals" Interview on 4/11/25 client #1's former Primary Care Physician (PCP) assistant reported: Was unaware of client #1's medication refusals in March 2025 Client #1 "suffers from a chronic condition of hypertension" Amiodipine treats client #1's high blood pressure (BP) Was concerned with client #1 refusing the Amiodipine because of the risks of her BP increasing 			after a client refuses administrations of m Instructions for whe were part of the me training. Additionally incident report will b by the staff on duty refusals. Once a clien refused medications then a level 2 inciden be completed in IRIS include notification of prescriber.	nedication . In to report dication y, a level 1 be completed for up to 2 int has three times int report will and will	
	informed her of cli March 2025	nistrator/Owner called her and ent #1's medication refusals in a history of refusing				
	- Verified her in MAR - She crossed (March MAR beca	25 staff #1 reported: itials on client #1's March 2025 out her initials on client #1's use she made an error igned client #1's MAR when er medications				

Interview of prediction of the section Number (n) reconverted (Division	Division of Health Service Regulation							
MHL 092-864 B. WNG 04/25/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STATE, ZIP CODE 109 EVENING STAR DRIVE ABSOLUTE HOME - APEX 109 EVENING STAR DRIVE APEX, NC 27502 PROVIDER'S PLAN OF CORRECTION 000000000000000000000000000000000000	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· -					
109 EVENING STAR DRIVE APEX, NC 27502 CMUID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE INECCEED BY FULL TAG PROVIDENTS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CONSERVED BEFICIENCY) OPENING PREFX (EACH CORRECTIVE ACTION SHOULD BE CONSERVED BEFICIENCY) V 123 Continued From page 106 V 123 Interview on 3/12/25 client #4 reported: - 00 2/20/25 be "took of with a man" - Left that night and came back the next morning - Didn1 take her malications with her when she left the facility on 2/20/25 - " Tieft out around 11pm (2/20/25) and came back at Sam (2/21/25)" Interview on 3/14/25 staff #1 reported: - Transported client #4 to her 2/20/25. Interview on 3/17/25 a nurse at client #4's Primary Care Provider revealed: - Was unaware client #4 hoped and missed her medication from 2/20/25-2/25/25 Interview on 3/19/25 the Qualified Professional (QP) reported: - Client #4 shouldn't experience any negative consequences from missing her medication for 5 days Interview on 3/18/25 the Qualified Professional (QP) reported: - Client #4 shouldn't experience any negative consequences from missing her medication for 5 days Interview on 3/18/25 the Qualified Professional (QP) reported: - Client #4 shouldn't experience any negative consequences from missing her medication for 5 days Interview on 3/18/25 the Qualified Professional (QP) reported: - Client #4 shouldn't experience any negative consequences from missing her medication the returned to the facility on 2/20/25. - The RN/Administrator/Owner was responsible for coordinating the clients' appointments, but she would have contactad clien			MHL092-894	B. WING		1			
109 EVENING STAR DRIVE APEX, NC 27502 PROVIDERS PLAN DF OPDERCIENCES (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PROVIDERS PLAN DF OPDERCIENCES (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PRETX PRETX PRETX (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PRETX PRETX PRETX (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG Opdet (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PRETX (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG Opdet (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PRETX (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG Opdet (EACH DERCIENCY MUST BE PRECIEDED BY TULL TAG PRETX (EACH DERCIENCY MUST BE PRECIED BY TULL TAG PRETX (EACH DERCIENCY MUST BE PRECIED BY TULL TAG PRETX (EACH DERCIENT BE TAG Opdet (EACH DERCIENT MUST BE PRECIENCED BY TULL TAG PRETX (EACH DERCIENT BY THE PRECIENCED BY TULL TAG PRETX (EACH DERCIENT BY THE PRETX PRETX (EACH DERCIENT BY THE PRETX<	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
PAU ID PREEX (EACH DEPORTS TATEMENT OF DEPORTACIES (EACH DEPORTS MARY STATEMENT OF DEPORTACIES) (EACH DEPORTS MARY STATEMENT OF DEPORTACIES) (EACH DEPORTS AND ADDRESS ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS		109 EVEN		ING STAR D	RIVE				
Mail Product reach definition of the precedence by Full. prefix Trigo reach concentry actions should be consistent of the precedence o	ABSOLU			27502					
Interview on 3/12/25 client #4 reported: - On 2/20/25 she "took off with a man" - Left that night and came back the next morning - Didn't take her medications with her when she left the facility on 2/20/25 - "I left out around 11pm (2/20/25) and came back at 5am (2/21/25)" Interview on 3/14/25 staff #1 reported: - Transported client #4 to her 2/28/25 medical appointment Interview on 3/17/25 a nurse at client #4's Primary Care Provider revealed: - Was unaware client #4 eloped and missed her medication from 2/20/25-2/25/25 Interview on 3/19/25 and 3/25/25 client #4's pharmacist reported: - Was unaware client #4 missed her medication from 2/20/25-2/25/25 Interview on 3/19/25 and 3/25/25 client #4's pharmacist reported: - Client #4 shouldn't experience any negative consequences from missing her medication for 5 days Interview on 3/18/25 the Qualified Professional (QP) reported: - Client #4 eloped on 2/20/25 - The RN/Administrator/Owner was responsible for coordinating the clients' appointments, but she would have contacted client #4's physicians If she knew client #4 was consuming alcohol Interview on 4/11/25 the QP reported: - Was unaware of client #1 is medication	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE		
 On 2/20/25 she 'took off with a man' Left that night and came back the next morning Didn't take her medications with her when she left the facility on 2/20/25 ''I left out around 11pm (2/20/25) and came back at 5am (2/21/25)'' Interview on 3/14/25 staff #1 reported: Transported client #4 to her 2/28/25 medical appointment Interview on 3/17/25 a nurse at client #4's Primary Care Provider revealed: Was unaware client #4 eloped and missed her medication from 2/20/25-2/25/25 Interviews on 3/19/25 and 3/25/25 client #4's pharmacist reported: Was unaware client #4 missed her medication for 2/20/25-2/25/25 Interview on 3/18/25 the Qualified Professional (QP) reported: Client #4 eloped on 2/20/25 Client #4 eloped on 2/20/25 Client #4 eloped on 2/20/25 Therview on 3/18/25 the Qualified Professional (QP) reported: Client #4 eloped on 2/20/25 Client #4 eloped on 2/20/25 The RN/Administrator/Owner was responsible for coordinating the clients' appointments, but she would have contacted client #4 was consuming alcohol Interview on 4/11/25 the QP reported: Was unaware of client #1 was 	V 123	Continued From pa	age 106	V 123					
- Was unaware of client #1's medication		 On 2/20/25 she Left that night a morning Didn't take her she left the facility "I left out arour back at 5am (2/21/ Interview on 3/14/2 Transported cl appointment Interview on 3/17/2 Primary Care Prov Was unaware her medication from 2/ Client #4 shou consequences from days Interview on 3/18/2 (QP) reported: Client #4 elope Client #4 'decishe returned to the The RN/Admir responsible for coor appointments, but client #4's physicla consuming alcoho 	e "took off with a man" and came back the next medications with her when on 2/20/25 and 11pm (2/20/25) and came (25)" 25 staff #1 reported: lent #4 to her 2/28/25 medical 25 a nurse at client #4's ider revealed: client #4 eloped and missed m 2/20/25-2/25/25 (25 and 3/25/25 client #4's ed: client #4 missed her (20/25-2/25/25 Idn't experience any negative m missing her medication for 5 25 the Qualified Professional ed on 2/20/25 lined medical treatment" when e facility on 2/26/25 histrator/Owner was ordinating the clients' she would have contacted uns if she knew client #4 was I						
Division of Health Service Regulation	Division of H	 Was unaware 	of client #1's medication			4 			

STATE FORM

8899

QE0011

If continuation sheet 107 of 170

PRINTED: 05/12/2025 FORM APPROVED

Division of Health Service Re Statement of deficiencies and plan of correction		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		R-	SURVEY LETED
		MHL092-884	B. WING		04/25/2025	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		¢.	
BSOLU	TE HOME - APEX		C 27502			(X6)
(X4) ID PREFIX TAG	WAND WEEKSLAD	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	DATE
V 132	Allegations, & Pro G.S. §131E-256 H REGISTRY (g) Health care far Department is not health care perso unknown source, any act listed in su (which includes: a. Neglect or abu facility or a perso as defined by G.S as defined by G.S b. Misappropriat in a health care fa (b) of this section care services as hospice services are being provide c. Misappropriat health care facility d. Diversion of c facility or to a pat e. Fraud agains a patient or client providing services Facilities must h acts are investiga- to protect resided investigation is in investigations mi Department with notification to the This Rule is not Based on record	IEALTH CARE PERSONNEL cilities shall ensure that the ified of all allegations against nnel, including injuries of which appear to be related to ubdivision (a)(1) of this section use of a resident in a healthcan h to whom home care services 3. 131E-136 or hospice services 3. 131E-201 are being provided ion of the property of a resider acility, as defined in subsection including places where home defined by G.S. 131E-136 or as defined by G.S. 131E-201 id. frugs belonging to a health car ient or client. t a health care facility or against for whom the employee is s). ave evidence that all alleged ated and must make every effort is from harm while the a progress. The results of all ust be reported to the in five working days of the initis	ee s i. ee st al ity	V132 HCPR Notificat responsibility of the investigate and repo- allegations of abuse, exploitation. QP accor responsibility for the incidents mentioned were not reported a This will not happen have been inservice supervision requirer residents in this hor time there is one re- not approved for un time in the home. C and the newly hired been educated on the requirements for pr supervision. At not the client or any other of not approved for un time be left alone in without staff supern	QP to rt any and all neglect and epts full e fact that the fact that the fact that the fact that the fact that the again. Staff d again, on ments for the ne. At this sident who is supervised urrent staff i staff have he roviding time will this since the home	

-2

TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
	MHL092-894		B. WING		1	-C 25/2025
IAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
BSOLU	TE HOME - APEX	109 EVE APEX, N	NING STAR DI C 27502	RIVE		
(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 T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 132	Continued From pa	ige 110	V 132		WU5.6	
	she threatened to a reported the staff w	attempt suicide. Client #4 also would retaliate if they knew she 4 was involuntarily committed				
	Medical Services (I revealed:	of client #4's Emergency EMS) report dated 11/18/24 ted to EMS she would be hurt				
	or killed by the staff	f if she went back into the to be transported to the				
	11/30/24 revealed: - Client #4 called	of a police report dated 911 because she and FS #4 nent" because FS #4 refused edications				
	 1/10/25 revealed: Client #4 called hadn't fed the client 	of a police report dated 911 and reported FS #3 is in 3 days and had old medication from her				
	1/12/25 revealed: - Clients #1, #3 a unsupervised time a facility alone. Client there were no staff	of a police report dated and #4 weren't approved and FS #3 left them in the #4 called 911 on client #1 and in the facility when the police lient #1 was involuntarily				
	Review on 3/12/25 (1/14/25 revealed: - Client #4 called hadn't fed the client	of a police report dated 911 and reported FS #3 s in 3 days and she was would retaliate for her calling				

Division of Health Service Regulation								
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
					R-C			
		MHL092-894	B. WING		1	5/2025		
			L					
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
ABSOLU	TE HOME - APEX		ING STAR E	DRIVE				
APEX, NC		27502						
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	D	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPRO		COMPLETE DATE		
				DEFICIENCY)				
V 132	Continued From pa	ae 112	V 132					
- / • •	F		VIUL					
	neglect to the HCP							
		supposed to report allegations						
	of neglect to the HC	al leave from October 11, 2024						
		eek of January 2025						
		istrator/Owner assumed some						
		she was on medical leave						
		and #4 didn't have approved						
	unsupervised time i	in the facility						
	 Was made awa 	are of FS #3 leaving the clients						
		hen the EMS contacted her on						
	1/12/25				4			
		arrived but she was unaware			I			
	Client #1 was escon	ted to the hospital by the EMS			Í			
	- Spoke with the in	RN/Administrator/Owner on icident and she "gave it (level						
		dministrator/Owner] to			1			
	handle"	armination owner] to			1			
		S #3 left clients #1, #3 and #4						
	alone for at least an							
		S #3 leaving clients #1, #3						
	and #4 alone was n	eglect because "[FS #3] was			i			
	only gone for a few	minutesbut I can see that						
		its alone for an hour) as						
	neglect"				4			
		f the 911 calls that were lober 2024 and January 2025						
		lient #4 was hospitalized on						
	11/18/24	adir ma nospitanzeu on			1	Í		
		t client #4's hospitalization						
		harmacy needed clarification						
	about physician ord	ers in January 2025						
	- The RN/Admini	strator "hadn't reported any			-	1		
	problems" with any	of the clients in the facility	ļ		i i			
Mark	- There were "no	major incidents in the home			1			
	(Tacility) that I'm awa	are of until the (client #4's)			1			
	elopement (2/20/25)							
	had to leave the faci	t her on 1/23/25 saying she						
		inverified fill-in staff and						
Division of He	alth Service Regulation				<u></u>			

STATE FORM

6899

QE0011

If continuation sheet, 113 of 170







