

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING II		STREET ADDRESS, CITY, STATE, ZIP CODE 431 JUNNY ROAD ANGIER, NC 27501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments Report of Biennial Construction Survey by Tod Hancock conducted on April 8, 2025. This facility was licensed on March 4, 1998, and is currently licensed as a Home for the Aged for 12 residents. Therefore, this facility was surveyed for conformance with the 1996 Minimum Standards and Regulations for Homes for the Aged, 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds and the 1996 (1998 Rev) Edition of the North Carolina State Building Code-section 419.5. Deficiencies were cited that will require a Plan of Correction.	C 000		
C 111	Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: 1. Based on an interview with the Executive Director and Maintenance Director, the facility failed to maintain in the facility, current (completed within the last twelve months) sanitation and fire and building safety inspection reports available for review. Findings on April 8, 2025: a. A copy of the current Fire Official's Annual Inspection report was not available for review. c. A copy of the current fire alarm system inspection report was not available for review.	C 111		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING II		STREET ADDRESS, CITY, STATE, ZIP CODE 431 JUNNY ROAD ANGIER, NC 27501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 111	Continued From page 1 d. A copy of the current fire sprinkler system inspection report was not available for review. e. A copy of the current health department inspection was not available for review.	C 111		
C 150	Corridors-Free of equipment and Obstructions SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: 1. Based on observation, hallways, doorways, and corridors were not free of obstructions. This would affect all residents, staff, and visitors by slowing or obstructing egress during an emergency. Findings on April 8, 2025: a. Right Hall- There were chairs obstructing the corridor and blocking the egress door.	C 150		
C 185	Fire Safety-Rehearsals on Each Shift SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING II		STREET ADDRESS, CITY, STATE, ZIP CODE 431 JUNNY ROAD ANGIER, NC 27501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 185	Continued From page 2 description of what the rehearsal involved. (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Review of records revealed the facility did not have a record of fire rehearsals being conducted quarterly on each shift. Findings on April 8, 2025: a. There were no records available to indicate that Fire Drills had been conducted.	C 185		
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation, the building was not maintained in a safe operating condition, because the portable fire extinguishers lacked the routine inspections documentation required to ensure proper performance. Failure to maintain fire safety equipment could affect occupants of the facility if the equipment does not function to suppress a fire. Findings on April 8, 2025: a. There was no documentation of the required monthly inspection of all the fire extinguishers.	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING II		STREET ADDRESS, CITY, STATE, ZIP CODE 431 JUNNY ROAD ANGIER, NC 27501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 189	Continued From page 3 2. Based on observation, the buildings' emergency equipment is not maintained in a safe operating condition. This could affect all if they could not promptly find their way to the exit during an emergency. Findings on April 8, 2025: a. Near Dining Room-The Emergency light did not illuminate when tested. 3. Based on observation the facilities, mechanical equipment is not being maintained in a safe manner. Findings on April 8, 2025: a. Laundry- The clothes dryer exhaust vent is not attached to the through wall connector.	C 189		