

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING		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 a Construction Section Biennial Follow Up Survey conducted by Tod Hancock on August 12, 2025. Deficiencies remain uncorrected. A new Plan of Correction is required.	{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 August 12, 2025: a. 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 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	{C 185}		

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: HAL043029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2025
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ASSISTED LIVING		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 1 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 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 August 12, 2025: a. There were no records available to indicate that Fire Drills had been conducted.	{C 185}		