STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL043-100	B. WING		05/	17/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
FREEDO	M CARE SERVCIES,	I I C #4	NNLEVEL ER	WIN ROAD		
		ERWIN, I	NC 28339	DDOVIDEDIO DI ANI OF CODDI	CTION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	TS .	V 000			
	An annual survey w 2018. Deficiencies	vas completed on May 17, were cited.				
	category: 10A NCA	ed for the following service C 27 G .5600C Supervised h Developmental Disabilities.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.					
	facility failed to con-	et as evidenced by: view and interviews, the duct disaster drills under ulate emergencies. The				
		of facility records revealed: aster drills conducted for				
		:#1 on 5/17/18 revealed: veral fire drills with them.				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	MHL043-100		B. WING		05/	05/17/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FREEDO	M CARE SERVCIES,	11 C #4	JNNLEVEL ER NC 28339	RWIN ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 1	V 114				
	-He did not recall st	taff ever doing a disaster drill.					
	Interview with client #2 on 5/17/18 revealed: -Staff had never conducted a disaster drill with them.						
	-He was admitted to	t #3 on 5/17/18 revealed: o the home in October 2017. ne any type of disaster drill					
	Interview with staff #1 on 5/17/18 revealed: -They did several fire drills with the clientsStaff had never conducted disaster drills with the clientsShe was not aware staff were supposed to conduct disaster drillsShe confirmed staff failed to conduct disaster drills under conditions that simulate emergencies.						
	on 5/17/18 revealed -It just recently cam were not conducting -She had talked to s fire and disaster dri -She confirmed stat	ne to her attention that staff g disaster drills. staff in the past about doing					
V 118	27G .0209 (C) Med	lication Requirements	V 118				
	only be administere order of a person adrugs.						

Division of Health Service Regulation

STATE FORM 6899 O61D11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL043-100	B. WING		05/	17/2018
	PROVIDER OR SUPPLIER  M CARE SERVCIES,	3560 BL	ADDRESS, CITY, S' INNLEVEL ERV NC 28339	*		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	clients only when a client's physician.  (3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug.  (5) Client requests checks shall be recorded.	uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse regally qualified person and re and administer medications amount in the total control (MAR) of the red to each client must be key a administered shall be rely after administration. The	ot			
		view and interview, the facility IAR current affecting one of	,			
	Review on 5/16/18 of client #3's record revealed: -Admission date of 10/5/17Diagnosis of SchizophreniaPhysician's order dated 5/7/18 for Clozapine 100 mg, one tablet in the morning, Benzoyl Peroxide 5% wash, use for showers and Vitamin D 50,000 IU, one capsule once a week on FridaysThe May 2018 MAR had blank boxes for					

Division of Health Service Regulation

STATE FORM 6899 O61D11 If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL043-100		B. WING		05/17/2018		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FREEDO	M CARE SERVCIES,	LLC #4 3560 BUN ERWIN, N	INLEVEL ER C 28339	WIN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Clozapine 100 mg of were documenting of IU was administered. The April 2018 MA Peroxide 5% washed documented on 4/1 D 50,000 IU was action. The March 2018 M were documenting of IU was administered. Interview with the Lion 5/16/18 revealed. She thought staff put that medications were the were no issupprescribed medication. Staff did document client #3 only get the The pharmacy wound pills a month.	on 5/10 PM and 5/13 PM. Staff daily that the Vitamin D 50,000 d. R had blank boxes for Benzoyl on 4/23 through 4/25. Staff through 4/8 that the Vitamin Iministered. IAR had the following: Staff daily that the Vitamin D 50,000 d. Idensee/Qualified Professional discossibly forgot to document the being administered. The Vitamin D daily, however at medication once a week. It will donly send four Vitamin D lity staff failed to keep the	V 118			
V 121	10A NCAC 27G .02 REQUIREMENTS (f) Medication reviev (1) If the client rece governing body or of for obtaining a reviev regimen at least ever shall be to be perfor physician. The on-sthe client's physicia the review when me (2) The findings of the		V 121			

Division of Health Service Regulation

STATE FORM 6899 O61D11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL043-100	B. WING		05/1	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FREEDO	M CARE SERVCIES,	I I C #4	NNLEVEL ER	WIN ROAD		
TREEDO		ERWIN, N	IC 28339			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  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)	JLD BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 4	V 121			
	corrective action, if	applicable.				
	failed to obtain drugtwo of three clients psychotropic drugs.  a. Review on 5/16/1 revealed: -Admission date of -Diagnoses of Schiz Major Depression D Chronic Obstructive Renal InsufficiencyPhysician's order of 3 mg, two tablets at mg, one tablet as nephysician's order of Carbonate 300 mg, The May 2018 MA administered the Trepropersion of the May 2018 MA administered the Trepropersion of the May 2018 mg, one fablet of the Trevealed: -Admission date of -Diagnosis of Schiz -Physician's order of mg, one tablet in the more tablet in the more series of the major of the maj	views and interview the facility reviews every six months for (#2 and #3) who received. The findings are:  18 of client #2's record  10/5/17.  zophrenia-Paranoid Type, Disorder, Hypertension, Pulmonary Disease and lated 3/22/18 for Risperidone bedtime and Trazodone 50 eeded for sleep. Lated 11/2/17 for Lithium one capsule two times daily. Revealed client #2 was azodone 50 mg on 5/11 to #2 was administered the late Lithium Carbonate 300 mg in the late of a six months eview for client #2.  18 of client #3's record  10/5/17.  ophrenia. Lated 5/7/18 for Clozapine 25 ee morning; Clozapine 100 mg, orning and two tablets at				
mg, one tablet in the morning; Clozapine 100 mg, one tablet in the morning and two tablets at bedtime; Lithium Carbonate 300 mg, three capsules at bedtime and Trazodone 100 mg, two						

Division of Health Service Regulation

STATE FORM 6899 O61D11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E SURVEY PLETED		
		MHL043-100	B. WING		05/·	17/2018
	PROVIDER OR SUPPLIER  OM CARE SERVCIES,	3560 RUN	INLEVEL ER	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 121	tablets at bedtimeThe May 2018 MA administered the ab -There was no evid psychotropic drug r  Interview with the L on 5/17/18 revealed -She was not award for clients who took -She confirmed the	R revealed client #3 was bove medication daily. ence of a six months eview for client #3.	V 121			

6899

Division of Health Service Regulation STATE FORM

O61D11 If continuation sheet 6 of 6