Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL043-102	B. WING		05/1	7/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	11C#6	OW FORD S N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	rs	V 000			
	on May 17, 2018. T substantiated (intak NC00138383). Defi The facility is licens category: 10A NCA	iplaint survey was completed the complaints were se #NC00138634 and sciencies were cited. sed for the following service C 27 G .5600C Supervised th Developmental Disabilities.				
V 109	10A NCAC 27G .02 QUALIFIED PROFINASSOCIATE PRO	ressionals no privileging requirements for hals or associate professionals. ssionals and associate demonstrate knowledge, skills ed by the population served. It is established by rulemaking, ssionals and associate demonstrate competence. hall be demonstrated by s including: ledge; ledge; less; g; kills;	V 109			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			E SURVEY PLETED		
		MHL043-102	2	B. WING		05/	17/2018
	PROVIDER OR SUPPLIER M CARE SERVICES,	LLC #6	34 SHALL	DRESS, CITY, S LOW FORD S N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 109	Continued From pa for the initiation of a plan upon hiring ea (g) The associate p supervised by a qua population served for specified in Rule .0	in individualized s ch associate profe professional shall alified professiona or the period of til	essional. be I with the me as	V 109			
	This Rule is not met as evidenced by: Based on record reviews and interviews, one of one Qualified Professionals (the Licensee/Qualified Professional) failed to demonstrate knowledge, skills and abilities to meet the needs of clients. The findings are: a. Review on 5/15/18 of client #1's record revealed: -Admission date of 4/22/18Diagnoses of Bipolar Disorder, Major Depressive Disorder, Depression, Post Traumatic Stress Disorder, Seizure Disorder, Anemia, Hyperlipidemia, Acute Renal Failure and Restless Legs Syndrome.						
	b. Review on 5/15/1 revealed: -Admission date of -Diagnoses of Schit Type and Major Vas with Behavioral Dis	4/18/18. zophrenia-Undiffe scular Neurocogni	rentiated				
	c. Review on 5/15/1 revealed: -Admission date of -Diagnoses of Schiz Disorder-Unspecific Hypertension and N	4/24/18. zophrenia-Unspeced, Hyponatremia,	ified, Bipolar				

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 2 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL043-102	B. WING		05/	17/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
FREEDO	M CARE SERVICES,	IIC#6	LLOW FORD S ON, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 109	Anemia. Review of the facility 5/16/18 revealed: -The Licensee/Quadate of 9/1/17. Review of facility re-An incident report "Auto Accident-[Stadrop clients off and lane and a car side called, report was not damages." Interview with client-They were involved weeks agoStaff #1 was drivin-A car hit the side of drivingAnother staff had they are they are the beginning of Marchiel and a minor and the beginning of Marchiel and a car side she did call the poshe does not have motor vehicleShe currently has a she only safe only had a Lear-She was the only safe and safe was the only safe was the saf	cy's personnel records on lified Professional had a hire cords on 5/15/18 revealed: dated 5/3/18 had the following ff #1] was on the way home to [Staff #1] switched to other swiped [Staff #1], police was nade, no injuries, no the company van. If the van while staff #1 was on pick them up. It was a driver's license and could the accident. #1 on 5/17/18 revealed: could the accident with the agency van and 2018. and clients from another on the van. It she was getting into anothe swiped the van. lice after the accident. It a driver's license to operate a learner's permit. If lified Professional was aware	d d			
	that accident.	staπ transporting clients during	9			

Division of Health Service Regulation

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL043-102	B. WING		05/17/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	1 1 C: #6	LOW FORD 5 N, NC 28326			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 3	V 109			
	-She had to call and -The other staff had their group homesShe transferred to beginning of April 2 -She had been tran alone since she tran Interview with the L on 5/15/18 and 5/17 -Staff #1 just recent the agency vanShe thought client' van during the accid -Staff #1 told her sh car side swiped the -Staff #1 does not h operate a motor vel -Staff #1 was the or during that accident -Staff #1 was the or during that accident -Staff #1 had to call accidentThe other staff had to the group homeStaff #1 was worki about a monthStaff #1 had been alone since she tran -She was aware wh only had a learner's -Staff #1 informed h her driver's licenseShe hired staff #1 one of her other ho	other staff after the accident. It to transport the clients to that group home at the 018. It is sporting clients on the van insferred to that home. It is sporting clients on the van insferred to that home. It is sporting clients on the van insferred to that home. It is sporting client with it is sporting client with it is sporting that is sporting that is sporting clients and a sporting client with it is sporting clients to hicle. In the police after the accident in the police after the ac				

Division of Health Service Regulation

This deficiency is cross referenced into 10A

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		MHL043-102	B. WING		05/1	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	I I C #6	.OW FORD 9 N, NC 28326			
(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)	D BE	(X5) COMPLETE DATE
V 109	Continued From pa	ge 4	V 109			
		Scope (Tag V-289) for a Type B just be corrected within 45				
V 110	0 27G .0204 Training/Supervision Paraprofessionals		V 110			
	SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession associate profession professional as special subchapter. (c) Paraprofession knowledge, skills as population served. (d) At such time as employment system then qualified profe professionals shall (e) Competence slexhibiting core skill (1) technical knowledge (2) cultural awarenedge (3) analytical skills (4) decision-makinedge (5) interpersonal service (6) communicationedge (7) clinical skills. (f) The governing service (6) the initiation of the initiation of the service (2) the service (3) analytical skills.	ledge; ess; ; g; kills;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		MHL043-10)2	B. WING		05/	17/2018
	PROVIDER OR SUPPLIER M CARE SERVICES,	LLC #6	34 SHALL	DRESS, CITY, S LOW FORD S N, NC 28326		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From pa	ge 5		V 110			
	This Rule is not me Based on record re three audited staff (demonstrate the kn required for the pop are:	views and intervious and intervious (staff #1) failed to wiledge, skills a	iews one of o and abilities				
	 a. Review on 5/15/18 of client #1's record revealed: -Admission date of 4/22/18. -Diagnoses of Bipolar Disorder, Major Depressive Disorder, Depression, Post Traumatic Stress Disorder, Seizure Disorder, Anemia, Hyperlipidemia, Acute Renal Failure and Restless Legs Syndrome. b. Review on 5/15/18 of client #2's record revealed: -Admission date of 4/18/18. -Diagnoses of Schizophrenia-Undifferentiated Type and Major Vascular Neurocognitive Disorder with Behavioral Disorder. 						
	c. Review on 5/15/1 revealed: -Admission date of -Diagnoses of Schir Disorder-Unspecific Hypertension and Nanemia.	4/24/18. zophrenia-Unspe ed, Hyponatremia	ecified, Bipolar a,				
	Review of the facilit 5/16/18 revealed: -Staff #1 had a hire -Staff #1 was hired -Staff #1 had a cop 3/6/17No evidence of a compart of the staff #1 had a cop 3/6/17.	date of 12/7/17. as a Paraprofes y of a Learner's I	sional. Permit issued				

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 6 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL043-102	B. WING		05/	17/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		34 SHALL	OW FORD S			
FREEDO	M CARE SERVICES,	I I C #6	N, NC 28326			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
V 110	Continued From pa	ge 6	V 110			
	motor vehicle.					
	-An incident report of "Auto Accident-[State drop clients off and lane and a car side	cords on 5/15/18 revealed: dated 5/3/18 had the following: ff #1] was on the way home to [Staff #1] switched to other swiped [Staff #1], police was nade, no injuries, no				
	Interview with client #1 on 5/15/18 revealed: -They were involved in a car accident a few weeks agoStaff #1 was driving the company vanA car hit the side of the van while staff #1 was drivingAnother staff had to pick them upStaff #1 did not have a driver's license and could not drive them after the accident.					
	-She had a minor at the beginning of Ma-Client's #1, #2, #3 group home were or -During the accident lane and a car side -She did call the porough -She does not have motor vehicleShe currently has at -The Licensee/Quasishe only had a Lear -She was the only stat accidentShe had to call and -The other staff had their group homes.	and clients from another n the van. t she was getting into another swiped the van. lice after the accident. a driver's license to operate a learner's permit. lified Professional was aware mer's permit. taff transporting clients during other staff after the accident. I to transport the clients to				

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 7 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED	
		MHL043-102	B. WING		05/1	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
FREEDO	M CARE SERVICES,	I I C #6	OW FORD S N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 110	Continued From pa	ge 7	V 110			
	-She had been transporting clients on the van alone since she transferred to that home.					
	on 5/15/18 revealed -Staff #1 just recent the agency vanShe thought client' van during the accident side swiped the Staff #1 told her should be swiped the Staff #1 does not hoperate a motor verstaff #1 was the orduring that accident -Staff #1 had to call accidentThe other staff had	tly had a minor accident with s #1, #2 and #3 were on the dent. he was switching lanes and a van. the police after the accident. her's permit. have a driver's license to hicle. hly staff transporting clients				
	to the group homeStaff #1 was working at the group home for about a monthStaff #1 had been transporting clients on the van alone since she transferred to that home.					
	NCAC 27G .5601 S	ross referenced into 10A Scope (Tag V-289) for a Type B Just be corrected within 45				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administere					

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 8 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			B WING			
		MHL043-102	B. WING		05/1	7/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	11(:#6	OW FORD S N, NC 28320			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	drugs. (2) Medications shat clients only when at client's physician. (3) Medications, incommodifications, incommodified and instered only build unlicensed persons pharmacist or other privileged to prepare (4) A Medication Act all 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 in the properties of the followed up by a with a physician. This Rule is not me Based on record refacility failed to kee two of three clients record administered.	all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, regally qualified person and a e and administer medications. Iministration Record (MAR) of red to each client must be kept a administered shall be ely after administration. The ne following: and quantity of the drug; and quantity of the drug; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	1. The following is a keep the MAR curre	evidence the facility failed to ent.				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES CAMERON, NC 28326
MHL043-102 B. WING 05/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FREEDOM CARE SERVICES, LLC #6 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
NAME OF PROVIDER OR SUPPLIER FREEDOM CARE SERVICES, LLC #6 STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
NAME OF PROVIDER OR SUPPLIER FREEDOM CARE SERVICES, LLC #6 STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
NAME OF PROVIDER OR SUPPLIER FREEDOM CARE SERVICES, LLC #6 STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
FREEDOM CARE SERVICES, LLC #6 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
FREEDOM CARE SERVICES, LLC #6 CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
(11)
(11)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)
V 118 Continued From page 9 V 118
a. Review on 5/15/18 of client #2's record
revealed:
-Admission date of 4/18/18.
-Diagnoses of Schizophrenia-Undifferentiated
Type and Major Vascular Neurocognitive Disorder
with Behavioral Disorder.
-Physician's order dated 4/18/18 for Docusate
100 mg, one capsule daily; Glycolox Powder 527
gm, mix 17 gms into 8 ounces of fluid daily;
Pantoprazole Sodium 40 mg, one tablet daily;
Lisinopril 40 mg, one tablet daily; Furosemide 20
mg, one tablet daily; Cardizem 120 mg, one
capsule daily; Cetirizine HCL 5 mg, one tablet
daily; Labetalol 200 mg, one tablet every 12
hours; Hydralazine 100 mg, one tablet every 8
hours; Prolixin 5 mg, one tablet two times daily;
Cyclobenzaprine 10 mg, one tablet three times
daily and Trazodone 100 mg, one tablet at
bedtime.
-The April 2018 MAR had blank spaces for the
following medications: Docusate 100 mg on 4/20;
Glycolox Powder 527 gm on 4/20, 4/25 through
4/30; Pantoprazole Sodium 40 mg on 4/20;
Lisinopril 40 mg on 4/20; Furosemide 20 mg on
4/20; Cardizem 120 mg on 4/20; Cetirizine HCL 5
mg on 4/20; Labetalol 200 mg on 4/20 AM dose
and 4/19 PM dose; Hydralazine 100 mg on 4/20
AM dose, 4/19 and 4/20 2 PM doses, 4/19 10 PM
dose; Prolixin 5 mg on 4/20 AM dose and 4/19
PM dose; Cyclobenzaprine 10 mg 4/20 AM dose,
4/19,4/20 and 4/25 2 PM doses, 4/19 and 4/20
PM doses and Trazodone 100 mg on 4/19.
Tim decee and mazedone for mg on ario.
b. Review on 5/15/18 of client #3's record
revealed:
-Admission date of 4/24/18.
-Diagnoses of Schizophrenia-Unspecified, Bipolar
Disorder-Unspecified, Hyponatremia,
Hypertension and Normocytic Hypochromic

Anemia.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		MHL043-102	B. WING		05/1	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
FREEDO	OM CARE SERVICES,	I I C #6	OW FORD S N, NC 28326			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-Physician's order of one tablet daily; Que two times daily; Trabedtime; Pravastatis bedtime and Divalpt tablets at bedtimePhysician's order of mg, one tablet threePhysician's order of mg, one tablet daily; Benztropine Maily; Buspirone Hodaily, Clobetasol O. affected area two tinomic mg, one tablet and through 5/5; Quetian 5/4; Trazodone 50 in Pravastatin Sodium Divalproex Sodium 5/4; Alprazolam 1 in doses, 5/1 through through 5/4; Aspirin Benztropine Mesylan Benztropine Mesylan Buspirone HCL 15 in Clobetasol 0.05% of doses and Cetirizin 5/4. Interview with the Lon 5/15/18 revealed she thought staff of that medications we thought client hospitalized at the light staff of the specific days of the staff of	dated 5/8/18 for Mobic 15 mg, etiapine 400 mg, one tablet zodone 50 mg, one tablet at n Sodium 20 mg, one tablet at roex Sodium DR 500 mg, five dated 5/3/18 for Alprazolam 1 etimes daily. dated 4/30/18 for Lisinopril 5 r; Aspirin 81 mg, one tablet desylate 1 mg, one tablet desylate 1 mg, one tablet two times 05% cream, apply topically to mes daily and Cetirizine HCL to bedtime. R had blank boxes for the ns: Mobic 15 mg on 5/1 through mg on 5/2 through 5/4; DR 500 mg on 5/2 through 5/4; DR 500 mg on 5/2 through ng on 5/1 through 5/5 AM 5/4 2PM doses and 5/1 oses; Lisinopril 5 mg on 5/1 through 5/4; ate 1 mg on 5/1 through 5/4; ate 1 mg on 5/1 through 5/4; aream on 5/1 AM and PM et HCL 10 mg on 5/2 through described being administered. Dessibly forgot to document dere being administered.	V 118			

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 11 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		MHL043-	102	B. WING		05/	17/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE	•	
				OW FORD S			
FREEDO	M CARE SERVICES,	LLC #6		N, NC 28326			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECED	DED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE DATE
V 118	Continued From page 11			V 118			
	MAR's current for c	lients' #2 and #	t 3.				
	 2. The following is evidence the facility failed to record administered medications immediately. Review on 5/15/18 of client #1's record revealed: -Admission date of 4/22/18. -Diagnoses of Bipolar Disorder, Major Depressive Disorder, Depression, Post Traumatic Stress Disorder, Seizure Disorder, Anemia, Hyperlipidemia, Acute Renal Failure and Restless 						
	Legs SyndromePhysician's order dated 5/10/18 for Furosemide						
	20 mg, one tablet d -Physician's order of		· Pantoprazole				
	40 mg, one tablet d	aily; Quetiapine	Fumarate 300				
	tablets at bedtime.	-	-				
	-Physician's order of 0.5 mg, one tablet of						
	one tablet in the mo						
	at bedtime and Pra- -Physician's order of						
	Mesylate 1 mg, one -Physician's order of						
	Sulfate 325 mg, one Vitamin C 250 mg,	e tablet three ti	mes daily and				
	-Physician's order of	lated 3/15/18 fo					
	40 mg, one tablet a -Physician's order of		· Docusate				
	Sodium 100 mg, or	e capsule two	times daily.				
	-Physician's order of Succinate ER 25 m						
	HCL 2.5 mg, one ta	blet three times	s daily;				
	Paroxetine HCL 40 Tegretol 200 mg, or						
	-Physician's order of	lated 11/24/17	for Gabapentin				
	300 mg, one capsu -There was no evid						
	MAR for the above		J. May 2010				

Division of Health Service Regulation

STATE FORM 6899 I8QV11 If continuation sheet 12 of 16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-102	B. WING		05/1	7/2018
	PROVIDER OR SUPPLIER	LLC #6 34 SHALI	DORESS, CITY, S LOW FORD S N, NC 28326			
(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)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 12	V 118			
V 289	-Staff did administe 22 through May 15, -Client #1 did not ha MARStaff were writing t bubble packsEach time staff add bubble pack they w -She confirmed star medications immed Interview with the L on 5/15/18 revealed -She was not aware 2018 MAR for clien -She confirmed star medications immed 27G .5601 Supervise 10A NCAC 27G .56 (a) Supervised livir provides residential	here initials on the medication ministered pills from the ould put their initials. If failed to record administered liately for client #1. icensee/Qualified Professional d: e there was no April or May t #1. If failed to record administered liately for client #1.				
	these services is the rehabilitation of individuals. A developm or a substance abusupervision when ir (b) A supervised live the facility serves e (1) one or more (2) two or more Minor and adult clies ame facility. (c) Each supervised	e care, habilitation or viduals who have a mental ental disability or disabilities, se disorder, and who require in the residence.				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		MHL043-102	B. WING		05/1	7/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FREEDOM CARE SERVICES, LLC #6 34 SHALLO CAMERON							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 289	designated below: (1) "A" design serves adults whos illness but may also (2) "B" design serves minors who developmental disa diagnoses; (3) "C" design serves adults whos developmental disa diagnoses; (4) "D" design serves minors who substance abuse do other diagnoses; (5) "E" design serves adults whos substance abuse do other diagnoses; (6) "F" design serves adults whos substance abuse do other diagnoses; (7) "E" design serves adults whos substance abuse do other diagnoses; (8) "F" design private residence, where adult clients whose primary developmental disa other disabilities, or three clients whose primary developmental disa other disabilities where the exempt from the form of the control of	nation means a facility which e primary diagnosis is mental o have other diagnoses; nation means a facility which se primary diagnosis is a bility but may also have other nation means a facility which e primary diagnosis is a bility but may also have other nation means a facility which e primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor	V 289				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL043-102	B. WING		05/	17/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	TATE, ZIP CODE			
FREEDO	M CARE SERVICES,	IIC#6	LLOW FORD S ON, NC 28326				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
V 289	Continued From pa	ge 14	V 289				
	alternative family liv (AFL).	ring or assisted family living					
	facility failed to ope the care, habilitation	et as evidenced by: s and record reviews, the rate and provide services for n and rehabilitation of three o 2 and #3). The findings are:	f				
	COMPETENCIES (PROFESSIONALS PROFESSIONALS Based on record re one Qualified Profe Licensee/Qualified	AND ASSOCIATE views and interviews, one of ssionals (the Professional) failed to edge, skills and abilities to					
	COMPETENCIES A PARAPROFESSIO Based on record re three audited staff (views and interviews one of staff #1) failed to owledge, skills and abilities					
	by the Licensee/Qu 5/17/18 revealed: What immediate ac ensure the safety o "The facility will not operable drivers license will the drivers license will the solution of the same of the s	of a Plan of Protection writter alified Professional dated stion will the facility take to f the consumers in your care: allow any staff without a sense to transport any facility. Staff with operable transport residents."					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL043-102	B. WING		05/1	7/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
FREEDOM CARE SERVICES,	1 I C #6	OW FORD S N, NC 28326				
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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)	D BE	(X5) COMPLETE DATE	
license upon hire a to assure licenses a also requires staff to license status immendified." Staff #1 had a accident transporting clients have a driver's license staff with the van duration of the van duration of the van duration of the van duration of the agency the beginning of Apconstitutes a Type to health, safety or violation is not correadministrative penalisis.	will double check all staffs nd every 6 months-1 year after are in good standing. Facility to report any changes in their ediately of them being dent with the agency van while on 5/3/18. Staff #1 did not use to operate a motor vehicle. The permit and was the onlying the accident. The Professional was aware that learner's permit. The Professional allowed staff #1 van to transport clients since will 2018. This violation B violation which is detrimental welfare of clients. If the ected within 45 days, alty of \$200.00 per day will be lay the facility is out of	V 289				