TO:19197158078 FROM:9194004852

Page: 2
PRINTED: 03/03/2019
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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING.		
		MHL036-332	B. WING		02/28/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
FREEDOM		1089 X RA	DRIVE		
		GASTONIA	, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	S	V 000		
	28, 2019. Deficiencie This facility is licensed category: 10A NCAC	is completed on February es were cited. If for the following service 27G .3100 Nonhospital In for Individuals who are		RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 9:41 am, I	Mar 19, 2019
V 119	10A NCAC 27G .020 REQUIREMENTS (d) Medication dispose (1)All prescription and medication shall be diguards against divers (2)Non-controlled subsoft by incineration, flust system, or by transfer destruction. A record shall be maintained be Documentation shall medication name, struction disposing of medicati witnessing destruction (3)Controlled substant accordance with the I Substances Act, G.S. subsequent amendm (4)Upon discharge of remainder of his or he disposed of promptly expected that the patit to the facility and in su	sal: If non-prescription isposed of in a manner that ion or accidental ingestion. In ostances shall be disposed shing into septic or sewer into a local pharmacy for of the medication disposal by the program. Ispecify the client's name, ength, quantity, disposal is signature of the person ion, and the person in. Incess shall be disposed of in North Carolina Controlled Isonothy of the person in. Incess shall be disposed of in North Carolina Controlled Isonothy of the person in. Incess shall be disposed of in North Carolina Controlled Isonothy of the person in or carolina controlled Isonothy or carolina Iso	V 119	V119 Freedom Detox will revimedication policy to state that expired or mislabeled medical brought to the facility by a part will be logged and disposed of transfer to a local pharmacy. necessary, the physician will medications to replace the disposed of medications. The agency's intake specialists be trained to advise patients in bring expired or mislabeled medications to the facility,	t "All 4/1/19 tions tient of by If order sposed

Division of Health Service Regulation

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

TITLE (X6) DATE

03/18/2019 09:09 AM PDT TO:19197158078 FROM:9194004852

Page: 3 PRINTED: 03/03/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL036-332	B. WING	B. WING 02		8/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
FREEDOM		1089 X RA				
			N, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 119	Continued From pag	e 1	V 119			
	expired medications 3 audited clients (Clients and Clients and Clients 2:10pm of Client #2's -Bottle of Simvastatir cholesterol and trigly 12/1/17 with pharmac discard after 12/1/18; -Bottle of Finasteride dispensed 12/14/17 with directions to discard a -Bottle of Mature Mulwith expiration date of 2/2 -Diagnoses of Opioid Disorder in Sustained Anxiety Disorder, Unsubject of Mature Mulwith expiration date of 2/2 -Diagnoses of Opioid Disorder in Sustained Anxiety Disorder, Unsubject of Mature Mulwith expiration Despenses of Opioid Disorder, Attention Despenses of Opioid Disorder in Sustained Anxiety Disorder, Unsubject of Disorder and Sustained Sustained Client Sustained Sustaine	record review, and lity failed to ensure that all be disposed affecting 1 of ent #2). The findings are: /19 at approximately s medications revealed: h 40mg (elevated ceride levels) dispensed cy label directions to j form (urinary retention) with pharmacy label lafter 12/1/18; litivitamins (supplement) of 8/2016. Client #2's record revealed: 23/19; Use Disorder, Alcohol Use I Remission, Unspecified specified Depressive efficit Hyperactivity Disorder; lated 2/24/19 for Simvastatin ling, and multivitamins. with the Registered the medication labels				
	revealed:	are onice / diffinancial				

TO:19197158078 FROM:9194004852

Page: 4 PRINTED: 03/03/2019

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Division of Health Service Regulation

	NO DEAN OF CORRECTION IN IDENTIFICATION NEIMBER		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.				
		MHL036-332	B. WING		02/2	8/2019	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, ST	ATE, ZIP CODE			
FREEDOM		1089 X RAY					
(VA) ID	SUMMARY ST	GASTONIA, ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		/VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE	
V 119	Continued From page	2	V 119				
	a client who presents	a policy on how to address to the facility for admission th appear to have expired place the medications					
V 131	Employment Verification G.S. §131E-256 HEAl REGISTRY (d2) Before hiring heat health care facility or shealth care facility shapersonnel Registry an access in the appropriation of the company of the com	Ith care personnel into a service, every employer at a all access the Health Care and shall note each incident of fate business files. Its evidenced by: It record review, the facility are health care personnel and the results documented ployment affecting 2 of 3 ons Coordinator and Office dings are: Ithe Admission Coordinator's	V 131	V131 Freedom Detox will ens that all employees and contra have a Healthcare Registry C prior to their start date. The H be filed in the personnel reco	ctors heck CR will	4/1/19	
	on 11/20/18.	el Registry Check completed the Office Administrator's					

03/18/2019 09:09 AM PDT

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page: 5

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE :	SURVEY LETED
			A. BUILDING:	A. BUILDING:		
		MHL036-332	B. WING		02/2	8/2019
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, ST.	ATE, ZIP CODE		
FREEDOM		1089 X RAY				
		GASTONIA	NC 28054	T		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETE DATE
V 131	Continued From pag	e 3	V 131			
	-Healthcare Personne on 11/19/18.	el Registry Check completed				
	Interview on 2/28/19 revealed:	with the Office Administrator				
	-Will ensure all Healt					
	Registry Checks are offer of employment	completed prior to an				
	oner or employment	m dio muro.				
V 133	G.S. 122C-80 Crimir	nal History Record Check	V 133	V133 Freedom Detox will ens that all applicants to fill a posi		4/1/19
	G.S. §122C-80 CRIM			that does not require the appl		
	RECORD CHECK RI APPLICANTS FOR E	EQUIRED FOR CERTAIN		to have an occupational licen	se i.e.	
		ed in this section, the term		MD, RN, LCAS will have a Cr		
		an area authority/county		Record Check pursuant to G.		
		vider of mental health,		§122C-80 Criminal History Re	ecord	
	•	ility, and substance abuse able under Article 2 of this		Check Required for Certain Applicants For Employment v	/ithin 5	
	•	offer of employment by a		days of a conditional offer of		
	provider licensed und	·		employment. The record che		
		ion that does not require the occupational license is		be filed in the personnel reco	rd.	
	• •	nt to a State and national				
	-	d check of the applicant. If				
		n a resident of this State for				
		hen the offer of employment sent to a State and national				
		d check of the applicant. The				
	national criminal histo	ory record check shall				
		e applicant's fingerprints. If				
		n a resident of this State for en the offer is conditioned				
		criminal history record				
	check of the applican					
		who refuses to consent to a				
		d check required by this nerwise provided in this				
		,	1			

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page: 6

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.2.1.2.1.1		,	A. BUILDING:		-	
		M#LII 026 222	B. WING	IG 02/3		0/2040
		MHL036-332			7 02/2	8/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
FREEDOM		1089 X RA GASTONI	Y DRIVE A, NC 28054			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
V 133	Continued From page	4	V 133			
	subsection, within five	business days of making				
		f employment, a provider				
	shall submit a request	to the Department of				
	Justice under G.S. 11	4-19.10 to conduct a				
	criminal history record	I check required by this				
	section or shall submi	t a request to a private				
	I -	ate criminal history record				
		section. Notwithstanding				
	· · · · · · · · · · · · · · · · · · ·	epartment of Justice shall				
		ational criminal history				
	· ·	ployment positions not				
	covered by Public Lav					
	Criminal Records Che	and Human Services,				
		ipt of the national criminal				
	•	the Department of Health				
		Criminal Records Check				
	· ·	rovider as to whether the				
		nay affect the employability				
		case shall the results of the				
		ry record check be shared				
		viders shall make available				
	•	ion that a criminal history				
	check has been comp	leted on any staff covered				
		nty that has adopted an				
		nance and has access to				
		al Information data bank				
	T	lf of a provider a State				
	· ·	I check required by this				
	· ·	ovider having to submit a				
		ment of Justice. In such a				
		commence with the State				
	_	I check required by this				
	section within five bus					
		ployment by the provider.				
	-	ormation received by the				
	· ·	al and may not be disclosed,				
	(c) of this section. For	nt as provided in subsection				
	(c) or ans section. For	purposes or triis				

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page: 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. DOLDING.	A. BUILDING: COM		
		MHL036-332	B. WING		02/	28/2019
NAME OF DE	OVIDED OD CURRUED	etneet /	DDDESS OFT STAT	TE 710 000E	•	
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE		
FREEDOM			AY DRIVE			
			IA, NC 28054			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 5	V 133			
		"private entity" means a				
	business regularly en					
	_	d checks utilizing public				
	records obtained from					
		icant's criminal history one or more convictions of				
		e provider shall consider all				
		rs in determining whether				
	to hire the applicant:	o in december of the control				
	• •	d seriousness of the crime.				
	(2) The date of t	he crime.				
	(3) The age of the	ne person at the				
	time of the convicti					
		tances surrounding the				
	commission of the	•				
	, , ,	tween the criminal conduct				
	be filled.	job duties of the position to				
		il, probation, parole,				
	·	ployment records of the the crime was committed.				
	•	ent commission by the				
	person of a relevant of					
	•	n of a relevant offense alone				
		employment; however, the				
		considered by the provider.				
		llifies an applicant after				
		relevant factors, then the				
	•	e information contained in				
	_	ecord check that is relevant				
	-	n, but may not provide a				
	• •	nistory record check to the				
	applicant.	- A provider and an officer				
		- A provider and an officer vider that, in good faith,				
		ction shall be immune from				
	civil liability for:	value original and middle morn				
	(1) The failure of the p	rovider to employ an				
		s of information provided in				
		•				

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page: 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFLANC	2 CONTECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED
			D. MINIG		
		MHL036-332	B. WING		02/28/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
FREEDOM		1089 X RA			
		GASTONIA	A, NC 28054		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 133	Continued From pag	e 6	V 133		
	the criminal history re	cord check of the individual.			
	•	n employee's history of			
	· ·	e employee's criminal			
		s requested and received in			
	compliance with this	section.			
	(e) Relevant Offense.	- As used in this section,			
	"relevant offense" me	ans a county, state, or			
		y of conviction or pending			
	· ·	whether a misdemeanor or			
	* '	on an individual's fitness to			
		r the safety and well-being of			
	_	ntal health, developmental			
		nce abuse services. These			
		minal offenses set forth in rticles of Chapter 14 of the			
	-	icle 5, Counterfeiting and			
	Issuing Monetary Sub				
		ve and Legislative Officers;			
		urticle 7A, Rape and Other			
		8, Assaults; Article 10,			
		iction; Article 13, Malicious			
	Injury or Damage by				
		Material; Article 14, Burglary			
	and Other Housebrea	akings; Article 15, Arson and			
	Other Burnings; Articl	e 16, Larceny; Article 17,			
		Embezzlement; Article 19,			
	False Pretenses and	*			
		Services by False or			
		edit Device or Other Means;			
	,	Transaction Card Crime Act;			
	·	ticle 21, Forgery; Article 26,			
	_	olic Morality and Decency; ablishments; Article 27,			
	· ·	ablishments; Article 27, B, Perjury; Article 29, Bribery;			
		t in Public Office; Article 35,			
	•	Public Peace; Article 36A,			
	_	lers; Article 39, Protection of			
		otection of the Family; Article			
	59, Public	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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	Ith Service Pegulation		L	<u>L</u>	L

03/18/2019 09:09 AM PDT

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page: 9

Division of Health Service Regulation

AND DIAM OF CORDECTION IN INCIDENTIAL AND DIAM OF CORDECTION AND DESCRIPTION A		' '	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-332	B. WING		02/2	8/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	•	
FREEDOM		1089 X RA	Y DRIVE			
		GASTONI	A, NC 28054			·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 133	Continued From page	e 7	V 133			
	Intoxication; and Artic Crime. These crimes or sale of drugs in vio Carolina Controlled S Chapter 90 of the Ge alcohol-related offens underage persons in or driving while impai 138.1 through G.S. 2 (f) Penalty for Furnish applicant for employm supplies, or otherwise an employment applic criminal history record shall be guilty of a Cla (g)Conditional Emploemploy an applicant obtaining the results record check regarding the following requirer (1)The provider shall prior to obtaining the acriminal history record subsection (b) of this fingerprint cards as re (2)The provider shall criminal history recordive business days af conditional employme 2001-155, s. 1; 2004	cle 60, Computer-Related also include possession plation of the North Substances Act, Article 5 of meral Statutes, and ses such as sale to violation of G.S. 18B-302 red in violation of G.S. 20-0-138.5. sing False Information Any ment who willfully furnishes, a gives false information on cation that is the basis for a dicheck under this section as A1 misdemeanor. Syment A provider may conditionally prior to of a criminal history ments are met: not employ an applicant applicant applicant's consent for a check as required in G.S. 114-19.10. submit the request for a dicheck not later than fer the individual begins				
		nd record review, the facility riminal background checks				

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page:

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL036-332	B. WING		- 02/28/2019	
NAME OF PE	ROVIDER OR SUPPLIER		I RESS, CITY, ST.	ATE ZIP CODE	UZIZ	6/2015
FREEDOM	OVIDER OR OUT FIELD	1089 X RAY		(1) L. 2002		
TREEDOM		GASTONIA,	NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 133	record revealed: -Hire date of 10/23/18 -Criminal background 11/20/18. Review on 2/28/19 of record revealed: -Hire date of 8/8/18; -Criminal background 11/19/18. Interview on 2/28/19 w revealed:	2 of 3 audited staff ator and Office andings are: the Admission Coordinator's 3; check completed on the Office Administrator's check completed on	V 133			
V 536	to restrictive interventi (b) Prior to providing disabilities, staff include employees, students of demonstrate compete completing training in other strategies for crewhich the likelihood of	TRAINING ON RESTRICTIVE plement policies and ize the use of alternatives ons. services to people with ling service providers, or volunteers, shall	V 536	V536 Freedom Detox will enter that all staff that have any corwith patients will complete alternatives to restraint and seclusion training i.e. NCI+ prestarting work. Documentation filed in the personnel record.	ntact	4/10/19

PRINTED: 03/03/2019 FORM APPROVED

Page: 11

Division of Health Service Regu	lation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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			B. WING		
		MHL036-332	B. WII4G		02/28/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
FREEDOM		1089 X RA	Y DRIVE		
		GASTONI	A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 536	Continued From page	9	V 536		
	property damage is pr	evented.			
		s shall establish training			
	based on state compe				
	internal compliance ar	nd demonstrate they acted			
	on data gathered.				
		be competency-based,			
	include measurable le				
		ritten and by observation			
	,	objectives and measurable			
	methods to determine course.	passing or railing the			
		training must be completed			
		der periodically (minimum			
	annually).	, , ,			
	(f) Content of the tra	ining that the service			
	1 5	ploy must be approved			
	by the Division of MH/	•			
	Paragraph (g) of this I				
	(g) Staff shall demon				
	the following core are:	as: and understanding of			
	(1) knowledge a the people being serve				
		and interpreting			
	human behavior;	and morproung			
		the effect of internal			
		that may affect people			
	with disabilities;				
		r building positive			
	relationships with pers				
		cultural, environmental			
	with disabilities;	ctors that may affect people			
		the importance of and			
	assisting in the persor	•			
	making decisions abo				
	-	essing individual risk			
	for escalating behavio	r;			
		ion strategies for defusing			
	and de-escalating pote	entially dangerous behavior;			

03/18/2019 09:09 AM PDT

TO:19197158078 FROM:9194004852

PRINTED: 03/03/2019 FORM APPROVED

Page:

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74601 2440	or corrections	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		-2125
		MHL036-332	B. WING		02/2	8/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	•	
FREEDOM		1089 X RA				
			NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	and (9) positive beh (providing means for p choose activities whice replace behaviors whice (h) Service providers documentation of initiation of initiation at least three years (1) Documenta (A) who particing the outcomes (pass/fa) (B) when and w (C) instructor's (2) The Divitiation of initiation of initiatio	navioral supports people with disabilities to th directly oppose or ich are unsafe). shall maintain tial and refresher training s. tion shall include: pated in the training and ail); where they attended; and name; sion of MH/DD/SAS materials and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate ag a passing grade on or training program. It is shall be clude measurable learning the testing (written and by or) on those objectives and to determine passing or to of the instructor training lans to employ shall be sion of MH/DD/SAS traph (i)(5) of this Rule. instructor training programs ot limited to presentation of: ing the adult learner;	V 536	DEFICIENCY)		
	(A) understandi	•				

TO:19197158078 FROM:9194004852

Page: 13
PRINTED: 03/03/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-332	B. WING		02/2	8/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE. ZIP CODE	1 02.2	
		1089 X RAY				
FREEDOM		GASTONIA,	NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETE DATE
V 536	(C) methods for performance; and (D) documentation (G) Trainers share experience teaching a preventing, reducing a restrictive intervention positive review by the (T) Trainers share aimed at preventing, represented for restrictive intervention annually. (B) Trainers share instructor training at le (j) Service providers should be documentation of initiation of initiation of initiation of the country of the outcomes (pass/fat	ion procedures. all have coached a training program aimed at and eliminating the need for as at least one time, with coach. all teach a training program reducing and eliminating the erventions at least once all complete a refresher ast every two years. shall maintain al and refresher instructor ree years. entation shall include: pated in the training and ail);	V 536			
	(C) instructor's (2) The Divisior request and review this (k) Qualifications of C (1) Coaches sharequirements as a traic (2) Coaches stimes the course whice (3) Coaches sharements of Coaches sharements are competence by computation-the-trainer instructions.	n of MH/DD/SAS may s documentation any time. oaches: hall meet all preparation half teach at least three h is being coached. half demonstrate letion of coaching or				

Page: 14

PRINTED: 03/03/2019 FORM APPROVED

D	ivision	of H	lealth	Service	Regu	lation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		MHL036-332	B. WING		02/28/2019				
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE					
FREEDOM									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IA, NC 28054 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE				
V 536	This Rule is not met a	e 12 as evidenced by: Based on eview, the facility failed to	V 536						
	ensure that all staff were trained in Alternatives to Restrictive Intervention prior to providing services affecting 1 of 3 audited staff (Admissions Coordinator). The findings are:								
	Review on 2/28/19 of record revealed: -Hire date of 10/23/18 -No training in Alterna Intervention.								
	Administrator revealer -The Admission Coord complete training in A Intervention today; -Did not realize the Ad needed to be trained	dinator was scheduled to Ilternatives to Restrictive dmissions Coordinator in Alternatives to in prior to starting work due intact; eceive training in ective Intervention prior							

Division of Health Service Regulation

STATE FORM NN8V11 If continuation sheet 13 of 13

CCO 3/13/19

Fax Transmission

To: 19197158078@nextivafax.com From: Carl Noyes

Fax: 19197158078 **Date:** 3/18/2019 9:09:14 AM PDT

RE: Emailing: freedom detox POC 036-332 2567 2-28 Pages: 14

Comments:

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

From: Carl Noyes, Freedom Detox

Re: POC

The original was mailed to your office