STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  MILLOS-102  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JP CODE  34 SHALLOW FORD STREET  CAMERON, N. C. 23325  PROVIDER'S AUTOMOTIVE CONSTRUCTION  (RADI ORDINARY STATELISMS TO DESCRIPTIONS  (RADI	Division o	f Health Service Regu	lation			
MALOS PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE, ZIP CODE  34 SHALLOW FORD STREET CAMERON, NC 23258  CAMERON, NC 23258  CAMERON, NC 23258  CRAMERON, NC 23258						
PREEDOM CARE SERVICES, LLC #6  24 ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCIES)  (PRETIX TAG SUMMARY STATEMENT OF DEFICIENCY  (PRETIX TAG SUMMARY STATEMENT OF DEFICIENCY  (PRETIX TAG SUMMARY STATEMENT OF DEFICIENCY  (PRETIX TAG SUMMARY STATEMENT OF DEFICE TO PRETIX TAG SUMMARY TAG SUMMA			MHL043-102	B. WING		
CAMERON, NC 28326   CAMERON (NC 28326   CAME	NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	
PREFIX REGULATORY OR LSCIDENTPYING INFORMATION)  V 000 INITIAL COMMENTS  A complaint survey was completed on April 20, 2020. The complaint was substantiated (intake #NC00161436). Deficiencies cited.  This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness  V 540 27F. 0103 Client Rights - Health, Hygiene And Grooming  10A NCAC 27F. 0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:  (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to tothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.  (b) Bathtuls or showers and toilets which ensure	FREEDOM	CARE SERVICES, LLC	#6		REET	•
A complaint survey was completed on April 20, 2020. The complaint was substantiated (intake #NC00161436). Deficiencies cited.  This facility is licensed for the following service category: 10A NCAC 27G. 5500A Supervised Living for Adults with Mental Illness  V 540 27F. 0103 Client Rights - Health, Hygiene Ard Grooming  10A NCAC 27F. 0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the proxision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:  (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to shave at least daily; (3) opportunity to shave at least daily; (a) opportunity to shave at least daily; (b) opportunity to shave at least daily; (c) opportunity to shave at least daily; (d) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to tothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.  (b) Bathtubs or showers and toilets which ensure	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE
equipped for use by a client with a mobility impairment shall be available.  TO REPOSE CIVAL CONTROL TO THE PROPERTY OF THE PR	∨ 000	INITIAL COMMENTS A complaint survey w 2020. The complaint #NC00161436). Defi This facility is license category: 10A NCAC Supervised Living for  27F .0103 Client Right Grooming  10A NCAC 27F .0103 AND GROOMING (a) Each client shall dignity, privacy and h of personal health, hy Such rights shall incl to the: (1) opportunity daily, or more often a (2) opportunity (3) opportunity (3) opportunity barber or a beauticia (4) provision o paper and soap for e individual personal h indigent client. Such not limited to toothpa napkins, tampons, sl utensil. (b) Bathtubs or show individual privacy show	as completed on April 20, was substantiated (intake ciencies cited.  d for the following service 27G. 5600A Adults with Mental Illness  as HEALTH, HYGIENE  be assured the right to numane care in the provision ygiene and grooming care. ude, but need not be limited  for a shower or tub bath as needed; to shave at least daily; to obtain the services of a n; and f linens and towels, toilet each client and other ygiene articles for each other articles include but are aste, toothbrush, sanitary having cream and shaving  wers and toilets which ensure all be available.	V 000	Facility Will ass personal hygienes are the facility over stock by stat following and con the inventory for the are due a month. Staff also communicate ap when items low to assure sh the items peron the items peron the items peron the items peron the residents to	we status fitems to the total to the tot
This Rule is not met as evidenced by:		impairment shall be	available.		they refuse bait	hing

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

TITLE

(X6) DATE

7RFR11

Division	of Hoolth Consider Boar	lation			FORM APPROVED
STATEMEN	of Health Service Regul t of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		MHL043-102	B. WING		04/20/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
FREEDO	A CARE SERVICES, LLC	#6	LOW FORD ST	REET	
		CAMERO	ON, NC 28326		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 540	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		V 540	excourages tre  (Deast 3x5 tD)  Their personal h  All residents are  a Shower sched  toassine treik  are confletal.  Facility M11 en  the residents a  advering to the  Schedule freet  been in place  auhice.  Staff will dash  resident appear  prior to them to  the hone of re  tre hone.	James. CN Le daily Mysterees Sure Le

waist to hold up pants.

-She was aware client #4 wore a string around his

-Client #4 was admitted without a belt; client #4

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	×	MHL043-102	B. WING		C 04/20/2020	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, ST		•	
FREEDOM	CARE SERVICES, LLC	#6	LOW FORD ST N, NC 28326	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	OM CARE SERVICES, LLC #6  SUMMARY STATEMENT OF DEFICIENCIES  34 SHALLO CAMERON,		V 542	Pesicients howe the to throw away the personal items and a natival consequenting go without of the facility hay so the 'Belt' twice working with the resident in Not away his personal and explaining to importance of keet them works for a day while he ge frustrated critical doesn't there are any lenger. We want to inform the form we to inform the personal items.	eine ence efter pleso  it hours items item	

7RFR11

Division	of Health Service Regu	lation			FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL043-102	B. WING		C 04/20/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	
FREEDON	CARE CERVICES II.C	#6 34 SHALI	LOW FORD STI	REET	
FREEDON	I CARE SERVICES, LLC	#6 CAMERO	N, NC 28326		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 542	funds in a personal fur (3) provide for the system of the	receipt and distribution of nd account; the receipt of deposits made rothers; the keeping of adequate II transactions affecting ersonal fund account; a client's personal funds will any operating funds of the the deduction from a transparent for treatment or when authorized by the client person upon or subsequent tient; the issuance of receipts to withdrawing funds; and client with a quarterly	V 542	ete their are pur by the facility of lahalf of the in Residents will so the receipt all fue financial te ance purchase is	for 1/19/20 Hes/ Heres, reversed mithe clivicid. SN ms u/ dser made
	facility failed to keep to assure funds were required for two of the The findings are:  Review on 4/13/20 - revealed: -Admission date of 8Diagnoses of Schizo Personality Disorders COPD, Obesity and Review on 4/13/20-4 document of Client #	ews and interviews, the adequate financial records managed in the manner ree audited clients (#5, #6).  4/20/20 of Client #5's record  /3/18. ophrenia Disorder, s, NOS, Diabetes Type 2,		Residents Will Consetting their ca allowance perface policy and significant they received to allowance after their medicate	ntinue. sh cility y thet we receiping

Division	of Health Service Regu	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMPER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL043-102	B. WING		C 04/20/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE, ZIP CODE	•
FREEDON	I CARE SERVICES, LLC	#6	OW FORD ST	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 542	amount of \$245.00.  -Monthly \$66.00 minuand received in cash.  -Monthly breakdown of for cigarettes + 120.0  -There were 10 cash 2020 with client #5's s  -The March 2020 pungroceries and day proThere were no receippurchases.  -There were no receipcompany's debit card  -The total current baladanuary 2020-April 20  Review on 4/13/20-4/revealed:  -Admission date of 12Diagnoses of Schizo Cholesterol and Alcoladbuse.  Review on 4/13/20-4/document of Client #6's guardian room/board.  -There was a monthly \$147.00 provided by -Monthly \$66.00 minuand received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com -There were no receipcompany's debit cardon receipcompany's debit cardon received in cash -Purchases made for snacks, etc with com	alance each month in the  Is medication copayment  of \$245.00 included \$125.00 0 for recreation, etc. purchases made in March signature. chases included fast food, orgam activity. ots for the March 2020  ots for any purchase from or cash on hand. ance after purchases from 020 was \$36.96.  20/20 of Client #6's record  2/8/17. ophrenia, GERD, High nol, Cocaine and Cannabis  //20/20 of a handwritten 6's funds/purchases  sent \$950.00/month towards y allowance in the amount of the guardian. us medication copayment  or cigarettes, personal items, pany's debit card. pts for any purchase from if or cash on hand, ance after purchases from if or cash on hand, ance after purchases from if or cash on hand, ance after purchases from if or cash on hand, ance after purchases from if or cash on hand, ance after purchases from if or cash on hand, ance after purchases from	V 542	are apple to spendallowance however allowance however allowance however allowance however allowance to spend out of resident necessary. Those will be in a lock and counted da Signed by reside Staff.	el their  rtug  rtug  rtug  res for  firels  box  uly

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ C B. WING 04/20/2020 MHL043-102 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 34 SHALLOW FORD STREET FREEDOM CARE SERVICES, LLC #6 CAMERON, NC 28326 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 542 V 542 Continued From page 5 Interview on 4/13/20 - 4/20/20 with the Owner/Qualified Professional revealed: -Clients received monthly \$66.00 in cash minus medication copayment. -Clients received additional allowance from guardian or other resources. -She managed and maintained additional allowance in the company's account. -Client #5's \$245.00 was documented on the company's ledger. -Client #5's monthly purchases of cigarettes and recreation was identified on the ledger. -Client #6's monthly purchases included cigarettes, personal items, coffee, snacks, etc. -Confirmed clients purchases were made on the company's debit card. -Confirmed there were no receipts for any of the purchases.

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