Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 50.12510			
		MHL036-332	B. WING		07/20/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
FREEDON	1	1089 X R	AY DRIVE			
FREEDON	"	GASTON	IA, NC 28054			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	on 7/20/21. One com (NC00177621) and o	aint survey was completed applaint was substantiated ne complaint was 00176684). Deficiencies				
	categories: 10A NCA Medical Detoxification Substance Abusers a	I for the following service C 27G .3100 Non-hospital of for Individuals who are nd 10A NCAC 27G .3300 cion for Substance Abuse.				
V 107	27G .0202 (A-E) Pers	connel Requirements	V 107			
	which: (1) specifies the competency, work ex qualifications for the p (2) specifies the the position; (3) is signed by supervisor; and (4) is retained ir (b) All facilities shall each staff member or provides care or servithe facility: (1) is at least 18	have a written job ector and each staff position eminimum level of education, perience and other position; duties and responsibilities of the staff member and the in the staff member's file. ensure that the director, any other person who ices to clients on behalf of				
	(3) meets the m competency, work ex qualifications for the p (4) has no subs	inimum level of education, perience, skills and other position; and tantiated findings of abuse or North Carolina Health Care				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
FREEDOM	Л	1089 X RA	Y DRIVE A, NC 28054			
(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 APPROPRICIENCY)) BE	(X5) COMPLETE DATE
V 107	applicants for employ conviction. The impa decision regarding er upon the offense in rewhich the applicant is (d) Staff of a facility currently licensed, reaccordance with appl services provided. (e) A file shall be ma employed indicating to	rvices shall require that all ment disclose any criminal ct of this information on a apployment shall be based elationship to the job for applying. or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including	V 107			
	failed to ensure a writ maintained affecting #4/Licensed Practical a file was maintained indicating training, ex qualifications for the paudited contract pers #1). The findings are Interview on 7/7/21 wattempted review on	nd record review, the facility ten job description was 1 of 6 audited staff (Staff I Nurse) and failed to ensure for each contract personnel perience, and other position affecting 1 of 1 ponnel (Contract Personnel				

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		MHL036-332	B. WING	B. WING		/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
FREEDON	Л		AY DRIVE				
			IA, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
V 107	Continued From page	e 2	V 107				
	-Employed as a Licer -When asked for a co- description, the Program was no job description Interview on 6/17/21 Administrator and atter Personnel #1's record -There was no record -When asked about of Personnel #1's job re experience, and qual Resources Administra Personnel #1 worked Technician. There was	nsed Practical Nurse; ppy of Staff #4's job ram Director revealed there n available for review. with the Human Resources empted review of Contract d revealed: I available for review; letails regarding Contract sponsibilities, training, ifications, the Human ator revealed Contract as a Behavioral Health ere no records maintained tel #1 as she was not an ty but was contracted brough a contracted					
	the Program Director -The facility had used healthcare personnel through 6/30/21, suppontracted staff. Interview on 6/29/21 Operations revealed: -No longer using contagencies to provide suppont in the person of the person of the person of Clinical Suppont in the person of th	with the Vice President of tracted healthcare personnel staffing for the facility. exit conference conducted rogram Director, Nurse sident of Operations, Vice Services and Quality secutive Vice President					
		of Operations revealed					

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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		07	//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FREEDON	1		RAY DRIVE			
			NIA, NC 28054			1
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 107	Continued From page	e 3	V 107			
	contract staff; -The Executive Vice I including those from opersonnel agencies, training, experience, descriptions prior to v The deficiency is cross NCAC 27G .3101 Scrule violation and mustages.	es referenced into 10A ope (V218) for a Type A1 st be corrected within 23				
V 100	(g) Employee training provided and, at a minor following: (1) general organizate (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subcommember shall be avaitimes when a client is member shall be trainincluding seizure man to provide cardiopulm trained in the Heimlice.	2 PERSONNEL tion shall be documented. g programs shall be nimum, shall consist of the tional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation ous diseases and is. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all is present. That staff	V 108			

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. , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING	B. WING		//20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE, ZIP CODE			
FREEDOM	Л		AY DRIVE IIA, NC 28054				
(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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
V 108	(i) The governing bo implement policies ar reporting, investigatir	ssociation or their ring airway obstruction.	V 108				
	failed to ensure all stageneral organizations and confidentiality, trathe clients served, and diseases and bloodbo of 6 audited staff (Stanurse, #4/Licensed F#6/Registered Nurse)	as evidenced by: nd record review, the facility aff received training in al orientation, client rights aining to meet the needs of id training in infectious orne pathogens affecting 6 aff #1, #2, #3/Registered Practical Nurse, #5, and) and 1 of 1 audited contract Personnel #1). The findings					
	-Hired 3/19/21; -Employed as Behaving -No training in client in and bloodborne pathor - Hired 12/7/20; -Employed as Behaving -No training in client in and bloodborne pathor - Hired 12/00/20;	f Staff #2's record revealed: ioral Health Technician; ights and infectious disease					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		MHL036-332	B. WING		07/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FREEDON	Л	1089 X RA	Y DRIVE A, NC 28054			
0(1) 15	CHMMADV CT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETE DATE
V 108	Continued From page 5		V 108			
	-Hired 8/17/20; -Employed as Registe -No training in client r and bloodborne patho	ights and infectious disease				
	Nurse's record reveal -Hired 3/8/21; -Employed as Licens	ed Practical Nurse; ights and infectious disease				
	Review on 6/17/21 of Staff #5's record revealed: -Hired 4/15/21; -Employed as Behavioral Health Technician; -No training in client rights and infectious disease and bloodborne pathogens. Review on 6/17/21 of Staff #6/Registered Nurse's record revealed: -Hired 3/1/21; -Employed as Registered Nurse; -No training in client rights and infectious disease and bloodborne pathogens.					
	the Program Director -The facility had used	email correspondence from dated 7/7/21 revealed: I six different contracted agencies from 1/1/21 olying a total of 27				
	Administrator and atte Personnel #1's record -There was no record -When asked about of Personnel #1's job re experience, and qual	l available for review; letails regarding Contract sponsibilities, training,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07	7/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
FREEDOM	Л		RAY DRIVE			
			IIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From page	e 6	V 108			
	Technician. There we	rough a contracted				
	Operations revealed: -No longer using cont agencies to provide s -Recognized deficits in a lack of training fo Technicians; -Recently implements	with the Vice President of cracted healthcare personnel taffing for the facility; with training which resulted r the Behavioral Health ed a new training system in CPR which began on				
	on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S Management, and Ex revealed: -The Vice President of Quality Management disconnect in new hir was implemented whi deficit; -The Executive Vice F was a requirement of to include client rights which should have be working with clients of employment. The lace	of Clinical Services and revealed there had been a se training but a new protocol ich will improve this training. President revealed there all staff to complete training and bloodborne pathogens seen completed prior to				
		ss referenced into 10A				

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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		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	1089 X F	ADDRESS, CITY, STATI RAY DRIVE NIA, NC 28054	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 108	Continued From page rule violation and mus days.	e 7 st be corrected within 23	V 108		
V 114	AND SUPPLIES (a) A written fire plantarea-wide disaster platashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each shift under conditions that	r EMERGENCY PLANS for each facility and an shall be developed and the appropriate local made available to all staff dures and routes shall be Irills in a 24-hour facility	V 114		
	failed to ensure fire an at least quarterly and The findings are: Review on 6/15/21 of Disaster Drill log reve -No fire and no disast during third quarter (J-No third shift fire drill: quarter (October - De-No first shift and third	nd record review, the facility and disaster drills were held repeated for each shift. the facility's Fire and aled: er drills were conducted uly-September) in 2020; s were conducted fourth			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FREEDOM	1	1089 X RA GASTONIA	Y DRIVE A, NC 28054			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page 8		V 114			
	and disaster drills at t -Took over as Region late September, 2020 passed away; -Began running fire at (7am-7pm) and secon -Aware that there wer	revealed: the coordination of all fire				
	on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S Management, and Ex revealed: -The Executive Vice F facility had experience of the former Regional was confident the cur	President President revealed the ed challenges with the loss al Maintenance Director but rent Regional Maintenance e fire and disaster drills were				
V 118	only be administered order of a person authorugs. (2) Medications shall	9 MEDICATION	V 118			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	SI GORREOTION	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		MHL036-332	B. WING		07/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
FREEDOM	Л	1089 X RA GASTONI	AY DRIVE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 118	administered only by unlicensed persons to pharmacist or other less privileged to prepare (4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record.	iding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. Ininistration Record (MAR) of d to each client must be kept administered shall be a fellowing:	V 118			
	failed to maintain a m	nd record review, the facility nedication administration rugs administered to each audited former clients				
	revealed: -Admitted 4/22/21; -Discharged 4/28/21; -Diagnosed with Opic	Former Client #6's record oid Use Disorder, Severe; or Anxiolytic Use Disorder,				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
FREEDOM	1	1089 X R	AY DRIVE			
TREEDON	•	GASTON	IA, NC 28054			
(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	(X5) COMPLETE DATE
V 118	Substance; Generaliz Sedative, Hypnotic, or Use Disorder, Modera -Medication orders da Nurse Practitioner revadministered daily individual benzodiazepine detox starting on day one witimes per day decreas 0.5mg once daily; Mutablet daily; Thiamine admission and then a (supplement) 1mg da administered on an as Simethicone 125mg as Famotidine 20mg twice sublingual every four four hours, Dicyclomic Milk of Magnesium 30 gastrointestinal protocoled time for sleep profevery 6 hours, Acetar hours, and Cyclobenz for pain protocol; Gabhours and Seroquel 2 anxiety protocol; and Cetirizine 10mg daily -No MAR was available Review on 6/14/21 of Reports revealed: -Incident Report date: #6 regarding discover Former Client #6's rodiscovered by a Behar	e Disorder, Severe; er, Mild, Amphetamine-type ded Anxiety Disorder; and r Anxiolytic Intoxication, with ate or Severe; ated 4/22/21 signed by the vealed: Medications to be cluded Klonopin (alcohol and dification protocol) taper ith 1mg (milligrams) three sed through day six with attivitamin (supplement) 1 (supplement) 100mg on s needed; and Folate ily. Medications to be seneeded basis included after meals or at bedtime, the daily, Zofran 4mg hours, Imodium 2mg every the 10mg every 6 hours, and tomic (milliliters) twice daily for col; Trazodone 100mg at tocol; Ibuprofen 600mg minophen 650mg every 6 traprine 10mg daily and for allergy protocol. the facility's Incident at 4/26/21 for Former Client try of 5 pills on the desk in	V 118			

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Interview on 7/7/21 with the Program Director

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· ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
FREEDOM	Л	1089 X RA GASTONI	Y DRIVE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 118	Client #6 was treated -There was no MAR a Former Client #6's reWas unable to identi present in Former Cli suggested that it prob the facility's electronic -Behavioral Health Te for scanning all treath former clients into the after the former client Behavioral Health Te work on the overnight Interviews during the on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S Management, and Ex revealed: -The Executive Vice F review of the matter t with scanning the rec scanned and uploade new protocol called fo documents are uploa initiate an electronic N Due to the failure to a medication administra determined if Former medications as order Furthermore, it could were located on Form 26, 2021.	e facility on 6/1/21; he facility when Former at the facility; available for review in cord; fy why there was no MAR ent #6's record but bably was not scanned into c system; chinicians were responsible nent paperwork regarding facility's electronic system is were discharged. The chinicians complete this t shifts. exit conference conducted rogram Director, Nurse sident of Operations, Vice Services and Quality facultive Vice President President revealed that upon here had been a breakdown ords. The MAR was not ad which was an error. A for confirmation that all ded. There is a plan to MAR moving forward. Inccurately document ation it could not be Client #6 received his	V 118			

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		MHL036-332	B. WING		07	//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
FREEDOM	Л		RAY DRIVE NIA, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 12	V 118			
		ope (V218) for a Type A1 st be corrected within 23				
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.				
	failed to access the H Registry (HCPR) and access in the approprial hiring health care per facility affecting 1 of 6 1 of 1 audited contract Personnel #1). The f Review on 6/17/21 of -Hired 12/7/20;	nd record review, the facility dealth Care Personnel note each incident of riate business file prior to sonnel into a health care addited staff (Staff #2) and ct personnel (Contract indings are:				
	-HCPR registry access 2/22/21. Review on 7/9/21 of 6	email correspondence from dated 7/9/21 revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
741512741	or connection	BENTI TO THOM NOMBER.	A. BUILDING:		COM LETES
		MHL036-332	B. WING		07/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
FREEDON	1		AY DRIVE		
			IIA, NC 28054		T
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 131	Continued From page	: 13	V 131		
	-The facility had used healthcare personnel through 6/30/21, supp contracted staff.	_			
	Personnel #1's record -There was no record -When asked about d Personnel #1's job recepterience, and quali Resources Administrat Personnel #1 worked Technician. There we on Contract Personnel employee of the facilit personnel provided the healthcare personnel Interview on 6/29/21 to Operations revealed: -No longer using contractions.	empted review of Contract I 6/17/21 revealed: available for review; etails regarding Contract sponsibilities, training, fications, the Human ator revealed Contract as a Behavioral Health ere no records maintained et #1 as she was not an ty but was contracted rough a contracted agency. with the Vice President of			
	on 7/20/21 with the Pi Practitioner, Vice President of Clinical Si Management, and Extrevealed: -The Executive Vice Fi policy in place for all si completed and document the facility. Contract is check completed but	exit conference conducted rogram Director, Nurse sident of Operations, Vice			
	The deficiency is cros	s referenced into 10A			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07	//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
FREEDON	Л		RAY DRIVE			
	T		NIA, 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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 131	Continued From page	e 14	V 131			
		ope (V218) for a Type A1 st be corrected within 23				
V 133	G.S. 122C-80 Crimin	al History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR E (a) Definition As us "provider" applies to a program and any providevelopmental disabiles services that is licensed to the services that is licensed under a provider licensed under applicant to fill a positive applicant to have an econditioned on consectiminal history record the applicant has been less than five years, it is conditioned on concriminal history record national criminal history	EMPLOYMENT. ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse sable under Article 2 of this n offer of employment by a				
	on consent to a State check of the applicant or criminal history record section. Except as other subsection, within five the conditional offer contains submit a requesion of the conditional offer conditional of	e criminal history record t. A provider shall not who refuses to consent to a d check required by this herwise provided in this e business days of making of employment, a provider st to the Department of 14-19.10 to conduct a d check required by this				

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MIII 000 000	B. WING		07/00/0004
		MHL036-332	B. W(0		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	ITE, ZIP CODE	
	_	1089 X R	AY DRIVE		
FREEDOM	ı	GASTON	IA, NC 28054		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
V 133	Continued From page	e 15	V 133		
	. •				
		it a request to a private			
		ate criminal history record			
		s section. Notwithstanding			
		Department of Justice shall			
		ational criminal history			
		ployment positions not			
	covered by Public Lav				
	•	and Human Services,			
	Criminal Records Che				
		eipt of the national criminal			
		the Department of Health			
		, Criminal Records Check			
		rovider as to whether the			
		may affect the employability			
		case shall the results of the			
		ory record check be shared			
	=	viders shall make available			
		tion that a criminal history			
	· · · · · · · · · · · · · · · · · · ·	oleted on any staff covered			
		nty that has adopted an			
	• • •	nance and has access to			
		al Information data bank			
	-	ılf of a provider a State			
		d check required by this			
		ovider having to submit a			
		ment of Justice. In such a			
	_	I commence with the State			
		d check required by this			
	section within five bus	•			
		nployment by the provider.			
	-	ormation received by the			
	=	al and may not be disclosed,			
		nt as provided in subsection			
	(c) of this section. For				
		"private entity" means a			
	business regularly en				
		d checks utilizing public			
	records obtained from				
	(c) Action If an appl	licant's criminal history			

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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		07/20/2021	
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STAT	FE, ZIP CODE		
FREEDOM	1089 X RA GASTONI	AY DRIVE A, NC 28054			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL : IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	D BE COMPLETE	
of the following factors in hire the applicant: (1) The level and serious (2) The date of the crime (3) The age of the perso conviction. (4) The circumstances is commission of the crime (5) The nexus between the person and the job of filled. (6) The prison, jail, probate rehabilitation, and employerson since the date the filled. (7) The subsequent commandary are levant offense. The fact of conviction of shall not be a bar to employer and disqualified consideration of the releprovider may disclose in the criminal history record to the disqualification, but of the criminal history record to the disqualification, but of the criminal history record to the disqualification, but of the criminal history record to the disqualification, but of the criminal history record to the disqualification, but of the criminal history record to the disquality for: (1) The failure of the provindividual on the basis of the criminal history record (2) Failure to check an ecriminal offenses if the ecriminal of	e or more convictions of provider shall consider all in determining whether to sness of the crime. e. on at the time of the surrounding the exift known. the criminal conduct of duties of the position to be ation, parole, pyment records of the exime was committed. In mission by the person of a relevant offense alone ployment; however, the ensidered by the provider. Evant factors, then the enformation contained in rid check that is relevant that may not provide a copy exord check to the eximple and an officer er that, in good faith, on shall be immune from the provider to employ an eximple of information provided in rid check of the individual. Employee's history of employee's criminal equested and received in	V 133			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		
			B. WING		
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		1089 X F	AY DRIVE		
FREEDON	1		IIA, NC 28054		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIAIE
				,	
V 133	Continued From page	e 17	V 133		
	(e) Relevant Offense	- As used in this section,			
		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			
		ital 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;			
		rticle 7A, Rape and Other			
		8, Assaults; Article 10,			
		ction; Article 13, Malicious			
	Injury or Damage by				
		Material; Article 14, Burglary			
	-	ikings; Article 15, Arson and			
		e 16, Larceny; Article 17,			
	•	Embezzlement; Article 19,			
	False Pretenses and	-			
		Services by False or			
		edit Device or Other Means;			
		Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against	~ .			
	-	Adult Establishments;			
		n; Article 28, Perjury; Article			
		, Misconduct in Public			
	<u>-</u>	enses Against the Public			
		iots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam				
		ele 60, Computer-Related			
		also include possession or			
		ion of the North Carolina			

Division of Health Service Regulation

Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related

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Division of Health Service Regulation

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/	20/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE			
FREEDON	Λ		IAY DRIVE IIA, 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 (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIO	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
V 133	violation of G.S. 18B-impaired in violation of G.S. 20-138.5. (f) Penalty for Furnish applicant for employn supplies, or otherwise an employment application of G.S. 20-138.5. (g) Conditional Employement application	e to underage persons in 302 or driving while of G.S. 20-138.1 through hing False Information Any nent who willfully furnishes, e gives false information on cation that is the basis for a d check under this section ass A1 misdemeanor. Ownent A provider may conditionally prior to of a criminal history record applicant if both of the its are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five the individual begins	V 133				
	failed to request a cri within 5 days of an of 1 of 1 audited contract Personnel #1). The f	nd record review, the facility minal background check fer of employment affecting ct personnel (Contract					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20125101			
		MHL036-332	B. WING		07/	20/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
FREEDOM	Л		IAY DRIVE IIA, 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 (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIO	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE
	-The facility had used healthcare personnel through 6/30/21, suppont contracted staff. Interview on 6/17/21 Administrator and attained the personnel #1's recorded to the personnel #1's job resuperience, and qual Resources Administration Personnel #1 worked Technician. There we on Contract Personnel employee of the facility	with the Human Resources empted review of Contract d revealed: I available for review; I etails regarding Contract sponsibilities, training, ifications, the Human entor revealed Contract as a Behavioral Health ere no records maintained el #1 as she was not an ty but was contracted				
	Operations revealed: -No longer using confagencies to provide s Interviews during the on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S Management, and Ex revealed: -The Vice President of had been a change to human Re expectation is that all complete of all requiric clients.	with the Vice President of tracted healthcare personnel staff for the facility. exit conference conducted rogram Director, Nurse sident of Operations, Vice Services and Quality secutive Vice President of Operations revealed there oprotocol as well as a source personnel and the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/20/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
FREEDOM	Л		RAY DRIVE NIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 133	Continued From page NCAC 27G .3101 Sco	20 ope (V218) for a Type A1	V 133		
	rule violation and mus days.	st be corrected within 23			
V 218	27G .3101 Nonhospit	al Med. Detox Scope	V 218		
	treatment and suppor supervision of a physi (b) This facility is des individual from alcoho	cal detoxification is a cility which provides medical tive services under the cian. igned to withdraw an or other drugs and to a more extensive treatment			
	failed to provide medi supportive services at current clients (Client	nd record review, the facility cal treatment and fecting 2 of 2 audited #1 and #2) and 4 of 4 (Former Client #3, #4, #5,			
	Personnel Requirements Based on interview are failed to ensure a write maintained affecting of #4/Licensed Practical a file was maintained indicating training, expendifications for the properties of the propert	nd record review, the facility ten job description was I of 6 audited staff (Staff Nurse) and failed to ensure for each contract personnel			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDTEAN	or dorace more	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII E	
		MHL036-332	B. WING		07/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FREEDON	1	1089 X RA` GASTONIA	Y DRIVE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 218	Continued From page	2 1	V 218			
	Personnel Requirements Based on interview at failed to ensure all state general organizations and confidentiality, that the clients served, and diseases and bloodbord of 6 audited staff (Stanurse, #4/Licensed Phe/Registered Nurse) personnel (Contract Final Contract Final Cont	and record review, the facility aff received training in all orientation, client rights aining to meet the needs of d training in infectious orne pathogens affecting 6 off #1, #2, #3/Registered tractical Nurse, #5, and and 1 of 1 audited contract Personnel #1). E: 10A NCAC 27G .0209 ents (V118) and record review, the facility redication administration rugs administered to each audited former clients				
	Criminal History Reco Certain Applicants for Based on interview at failed to access the H Registry (HCPR) and access in the approprial hiring health care per facility affecting 1 of 6 1 of 1 audited contract Personnel #1).	nd record review, the facility lealth Care Personnel note each incident of riate business file prior to sonnel into a health care addited staff (Staff #2) and of personnel (Contract E: General Statute 131E				
	failed to request a cri within 5 days of an of	el Registry (V133) nd record review, the facility minal background check fer of employment affecting ct personnel (Contract				

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/20/	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FREEDOM	1	1089 X RA GASTONIA	Y DRIVE A, NC 28054			
(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	(X5) COMPLETE DATE
V 218	Continued From page	22	V 218			
	Personnel #1).					
	Staff (V219) Based on interview at failed to ensure trainit withdrawal symptoms symptoms of secondary substance abuse, undediction, the withdrawal therapy, family therapy methodologies affectiful, #2, #3/Registered Practical Nurse, #5, and 1 of 1 audited con Personnel #1). The first CROSS REFERENCIOPERATION (V220) Based on interview at failed to monitor and rate, blood pressure, every four hours for the following for the failed to audited current cand 4 of 4 audited for #3, #4, #5, and #6) at	derstanding the nature of wal syndrome, group by, and other treatment ng 6 of 6 audited staff (Staff Nurse, #4/Licensed nd #6/Registered Nurse) ntract personnel (Contract				
	Training on Alternative Interventions (V536) Based on interview at failed to ensure all state were trained in alternative interventions prior to 2 of 6 audited staff (S #6/Registered Nurse)	nd record review, the facility aff and contracted personnel atives to restrictive providing services affecting taff #5 and Staff				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2.1.2.1.0.1.001.1.201.101.1		A. BUILDING: _				
	MHL036-332	B. WING		07/	20/2021	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
	1089 X R	AY DRIVE				
FREEDOM	GASTON	IIA, NC 28054				
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
Training in Seclusion, Isolation Time-Out (V5 Based on interview and failed to ensure all staf were trained in seclusic isolation time-out prior affecting 2 of 6 audited #6/Registered Nurse) a contracted personnel (Finding #1 Review on 6/17/21 and #4's record revealed: -Admitted 4/30/21; -Discharged 5/7/21; -Diagnosed with Alcohologed Secure; Attention Defice Generalized Anxiety Discharge Summary of had been admitted and (detoxification) of alcohologed benzodiazepines. Review on 6/17/21 and #5's record revealed: -Admitted 5/1/21; -Discharged 5/3/21; -Diagnosed with Alcohological Use Disorder, Secure Remission; Stimulant Usustained Remission; Attention Deficit Hyper Personal History of Psi-History and Physical Activation 2:35pm completed by revealed the patient was	: 10A NCAC 27E .0108 Physical Restraint and 37) d record review, the facility f and contracted personnel on, physical restraint, and to providing services I staff (Staff #5 and Staff and 1 of 1 audited Contract Personnel #1). d 7/7/21 of Former Client ol Use Disorder, Severe; Anxiolytic Use Disorder, cit Hyperactivity Disorder; dated 5/6/21 revealed he d treated for detox nol, Buprenorphine, and d 7/7/21 of Former Client ol Use Disorder, Severe; Severe in Sustained Use Disorder, Severe in Sustained Use Disorder, Severe in Bipolar II Disorder, activity Disorder; Other ychological Trauma; Assessment dated 5/2/21 at	V 218				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
			A. BOILDING.		
			B. WING		
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
EDEEDO!		1089 X R	AY DRIVE		
FREEDON	Л	GASTON	IIA, NC 28054		
(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 SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE
V 218	Continued From page	e 24	V 218		
	used in 2019), and opioids (last used in 2018). The plan of care included detox with CIWAs				
	-				
	,	ndrawal Assessment) and "			
	_	and vitals per protocol;" ration Record revealed			
	Alcohol Detox Protoc				
		am, 6am, 12pm, and 6pm.			
		ecorded on 5/2/21 at 6am;			
		Record dated 5/2/21 was			
		on from 5pm through 7pm			
	_	cumentation for 5/3/21;			
	-CIWAs completed or	n 5/1/21 at 9:03am resulted			
	in a rating of 12, 5/2/2	21 at 12:56am with a rating			
	of 5, 5/2/21 at 6:37am	n with a rating of 5, 5/2/21 at			
	5:33pm with a rating	of 14, 5/2/21 at 11:03pm			
	with a rating of 17 (Cl	IWA Scale revealed a score			
	of 0-7 indicated minin	nal to mild withdrawal, a			
		ed moderate withdrawal, and			
		licated severe withdrawal			
	and impending deliriu	•			
		5/3/21 at 12:04am included			
		6/110, pulse 98, respirations			
	taken by Staff #5;	x) 96%. The vitals were			
		ented as written on 5/3/21 at			
		egistered Nurse revealed: "			
		f 7 of CIWA protocol for			
		ented x4. Noted isolated to			
	self relaxing in bed. o	iety and sweating. Mild			
		restless and agitation			
	observed. Last CIWA	S .			
		ect. Pt observed sleeping			
	-	out any further disturbances			
	related to withdrawal				
		ented as written on 5/3/21 at			
		egistered Nurse revealed: "			
	Approx (approximat	_			
		echnician) on duty came to			
		ng me that pulse ox was in			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL036-332	B. WING		07	7/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
		1089 X I	RAY DRIVE			
FREEDO	И	GASTO	NIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
V 218	Continued From page	e 25	V 218			
	40-50 range Went in	n to assess patient and				
		olor, labored breathing and				
		to arouse. 911 called,				
	defibrillator applied, advised not to shock, chest					
	1	d until EMS (Emergency				
	Medical Services) arr	rived. EMS administered				
		ctrocardiogram) applied,				
		rith o2 (oxygen). No effect,				
		on. One nurse notified to				
	1	ient. Notified NP (Nurse				
		Patient transferred to				
	hospital 5:55am;"	antad as weither as 5/2/24 at				
	-Nursing note documented as written on 5/3/21 at 7:16am by Staff#6/Registered Nurse revealed: "					
	_	on duty at approx. 5:00am				
		bp (blood pressure) 110/44,				
	pulse 64, respirations					
	saturation) 47, Tempe					
	,	ary available for review.				
	Review on 6/14/21 of Reports revealed:	f the facility's Incident				
	-	d 5/3/21 at approximately				
	5:15am for Former C					
		ctical Nurse revealed: "				
	Tech (Behavioral H	ealth Technician - Staff #5)				
		station to let the nurse know				
		n oxygen saturation of 47.				
	,	egistered Nurse) left the				
	_	o assess the patient and the				
	`	Licensed Practical Nurse) on				
	duty accompanied the					
		Nurse). Patient was found on head facing to the left side.				
		nead lacing to the left side. ve to verbal cues. First				
		tered Nurse) left to call 911,				
		(Staff#4/Licensed Practical				
		d and continued to try to				
	arouse the patient. T					
	unresponsive at that					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR\	VEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETE	
						
		MHL036-332	B. WING		07/20/2	2021
					1 01/20/2	1021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
FREEDON	1	1089 X R				
		GASTON	A, NC 28054			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 218	Continued From page	26	V 218			
V 218	(Staff#4/Licensed Pratech to grab the defibitech came back to the nurse (Staff#6/Regist the room with EMS (EServices) on the phore (Staff#4/Licensed Praambu bag to try to ox ambu bag could not be nurse on the phone with Nurse) applied to the advised at that time. (Staff#6/Registered Nurse (Staff#4/Licens CPR (cardiopulmonar second nurse (Staff#4/Licens CPR (cardiopulmonar second nurse (Staff#6/Registered Non patient. CPR contand took over the see Narcan to patient with continued to assess than an EKG. No infoleowere provided to the lowest the loaded onto transported to the host conduct direct observation issued 1 and revised 6/22/18 in conduct direct observation of the loaded onto the conduct direct observation, with notation of the loaded onto the loaded of the loaded onto the loaded of the loaded onto	actical Nurse) instructed the rillator from the wall. The eroom with the The first ered Nurse) came back to Emergency Medical ne while the other nurse actical Nurse) left to get an avgenate the patient. The period left of the located at the time. The with EMS (Staff#6/Registered patient and no shock was Then the first nurse lurse) instructed the 2nd ed Practical Nurse) to begin ray resuscitation). The dividence of Practical Nurse while the first nurse lurse) gave mouth to mouth inued until the EMS arrived and effect and then the patient, perform vitals, rmation for those results nursing staff. The patient of the stretcher and spital via ambulance" The facility's Policy and Manual revealed: eentitled 'Detox /15/13, reviewed 8/13/17, evealed: "Staff will ation rounds observing each of whereabouts, at intervals of aily without interruption	V 218			
	reported to the nurse whereabouts will be d	physical condition will be on dutyThe client's locuments on the Client he staff's initials will be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		MHL036-332	B. WING		07/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FREEDON	Л	1089 X RA GASTONI	AY DRIVE 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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
V 218	Client Observation For permanent part of the Permanent part of the Review on 5/28/21 of Communications Call dated 5/3/21 at 5:23:0 Client #5 revealed: -The caller on the 91: Staff#6/Registered NStaff#6/Registered N instructions" provided the provided register of the staff#6/Registered NStaff#6/Registered NStaff#6/Registered NStaff#6/Registered NStaff#6/Registered NAt 1 minute and 16 soperator inquired if the composition of the staff#6/Registered NAt 1 minute and 26 soperator inquired if the staff#6/Registered NAt 1 minute and 39 soperator advised to sAt 2 minutes and 30 911 operator asked if and Staff#6/Registered one;"At 2 minutes and 50	ach observation notedthe orm will become a e client's medical record" If the local county's Police of for Service Detail Report Of the Office of for Service Detail Report Office of Service Office Office of Service Office Office Office of Service Office	V 218	DEFICIENCY)		
		e to get one; seconds into the call, the 911 about a defibrillator and				

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DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLI	ETED
			/ BOILDING		1	
		MHL036-332	B. WING		07/2	0/2021
			_ I		· •···=	0.202.
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
FDFFDOM	-	1089 X R	AY DRIVE			
FREEDON	1	GASTON	A, NC 28054			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1 .5	PROVIDER'S PLAN OF CORRECTION	N.	0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
170		,	IAG	DEFICIENCY)		
V 218	Continued From page	e 28	V 218			
	there was no answer from Staff#6/Registered					
		irom Stall#6/Registered				
	Nurse;					
		seconds into the call, the				
	911 operator asked a	gain about the defibrillator				
	and provided direction	ns to Staff#6/Registered				
	Nurse on how to use	the defibrillator;				
	-At 4 minutes and 37	seconds into the call, the				
	defibrillator was analy					
	•	seconds into the call, the				
		o shock recommended;				
		econds into the call, the 911				
		•				
		taff#6/Registered Nurse to				
	•	nd check the airway and				
	throat to ensure they					
		seconds into the call, the				
	911 operator asked if	the patient could be moved				
	from the bed and Stat	ff#6/Registered Nurse				
	advised he was too he	eavy;				
	-At 5 minutes and 51	seconds into the call, the				
	911 operator asked S	taff#6/Registered Nurse if				
	she was ready to com					
	-At 5 minutes and 54	•				
	Staff#6/Registered No					
		ssions had not been initiated				
	•					
	•	oking for an ambu bag;				
		seconds into the call the				
	•	that she really wanted chest				
	compressions begun;					
		seconds into the call, the				
	911 operator advised	to start compressions and				
	began giving instruction	ons on how to complete				
	compressions;	·				
		seconds into the call, the				
	compressions were s	•				
	•	lar to that of bed springs				
		jiving way in a rhythmic				
	manner.					
	D : 0/0/04 1-	01: 1 5: 1				
	REVIEW ON 6/2/21 Of F	ormer Client #5's Discharge	1	1		

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Summary dated 5/5/21 from a local hospital

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		MHL036-332	B. WING		07/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
FREEDON	1		AY DRIVE		
			IIA, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 218	Continued From page	e 29	V 218		
	revealed: -"Patient (Former (male with medical prosubstance abuse, wh (Emergency Departm Detoxification (Facility unresponsiveness took 2 Subutex (Subodetoxification center. being given Klonopin resident for Subutex. night and one the mo ED)Patient was discondition" Interview on 6/8/21 w revealed:	Client #5) is a 23 year old oblems significant for o presented to the ED tent) from Freedom y) center for episode of The patient stated that he oxone) while in the He stated that he was and that he traded another He took one earlier in the rning of admission (to the scharged home in good			
	-Was at the facility to detox from heroin; -Was taking Subutex and Seroquel while at the facility; -Medication administration at the facility was observed by the nurses; -Former Client #5 snuck Subutex into the facility; -Denied giving Subutex to any client; -Needed his Subutex as ordered to prevent a challenging detox experience with detox problems or withdrawal symptoms. Interview on 6/8/21 with Former Client #5 revealed: -Was a client at the facility in May, 2021 for alcohol detox; -Did not recall getting sick and going to the hospital while a client at the facility; -Received Subutex from Former Client #4 on 5/2/21 at approximately 10-11pm but did not feel the effects of the Subutex so Former Client #4 gave him a second Subutex to take; -Former Client #4 had snuck 7 Subutex into the facility at admission;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			_		
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
FREEDOM	1		AY DRIVE		
			IA, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 218	Continued From page	e 30	V 218		
	happening to him so and went unconsciou -Had a previous hero felt the same way dur on heroin as he did w Subutex from Former -Never reported the ir Client #4's Subutex to -Had been administer -The facility staff did r medication administra some of the pills; -Was administered ar the first day of treatm medications for the refacility; -Former Client #5 trac with Former Client #4 Subutex (Former Client	felt as if something bad was the wrote the serenity prayer s; in overdose in 2018 and he ring the previous overdose when he took the two client #4; incident of taking Former of anyone at the facility; and really watch him during ation so it was easy to hide and took Klonopin and Ativan ent and then "cheeked" the emainder of his time at the ded his "cheeked" Klonopin for Former Client #4's ent #5 provided Former onopin and Former Client #4			
	emergency contact/fa -Former Client #5 wa 5/1/21 for alcohol con	with Former Client #5's ather revealed: s admitted to the facility on asumption and use of energy			
	drinks; -Facility staff found Former Client #5 in cardiac arrest and sent him to the hospital via EMS while completing CPR; -Received a voicemail on 5/3/21 at approximately 7am informing that Former Client #5 was taken to the emergency room due to "some sort of infection;" -Called the facility for additional information but his calls were not returned and the calls went no				
	further than the recen				

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 2.1.1.1			A. BUILDING: _			
		MHL036-332	B. WING		07/	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
	_	1089 X R	AY DRIVE			
FREEDON	Л	GASTON	IA, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 218	Continued From page	e 31	V 218			
	Attempted interview of Contract Personnel # multiple rings, the phrace "call failed" message second attempted int at 1:42pm. A message	on 7/6/21 at 8:25am with 1 was unsuccessful. After one stopped ringing and a appeared on the screen. A erview was made on 7/6/21 ge was left on the voicemail all. No return call was				
	Interview on 6/17/21 with Staff#4/Licensed Practical Nurse revealed: -Employed as a Licensed Practical Nurse (LPN); -Worked the overnight of 5/2/21 to 5/3/21; -Holds current certification in American Red Cross CPR; -Staff #5 came to the nursing office early in the morning of 5/3/21 and reported Former Client #5's oxygen saturation was in the 40s; -Staff#6/Registered Nurse immediately headed to Former Client #5's room with Staff#4/Licensed Practical Nurse following to assist as needed; -Former Client #5 was lying on the bed on his stomach with labored breathing; -Staff#4/Licensed Practical Nurse and Staff#6/Registered Nurse tried to arouse Former Client #5; -Staff #5 was sent to retrieve the AED (Automated External Defibrillator); -Staff#6/Registered Nurse left to get the telephone to call 911 while Staff#4/Licensed Practical Nurse continued to attempt to arouse Former Client #5; -Staff#6/Registered Nurse returned to Former Client #5's room with the telephone while talking with the 911 operator; -Staff #5 returned with the AED which was placed on Former Client #5 but no shock was ordered; -The 911 operator instructed Staff#6/Registered Nurse to start CPR; -There was discussion between Staff#4/Licensed					

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL036-332	B. WING		07/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
FREEDON	Ī	1089 X RA	Y DRIVE		
T KLLDON		GASTONIA	A, NC 28054		
(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 218	Continued From page	e 32	V 218		
V 218	regarding an ambu bat found; -Rolled Former Client compressions but coubed to a hard surface was such a big man; -Staff#4/Licensed Pracompressions while Scompleted rescue bre-Staff#6/Registered N-Followed the directiv Nurse who was a Regupon the scope of the Interview on 6/17/21 r-Worked with Contract 30 minute rounds as rentered Former Client approximately 5am and -Observed Former Clien	staff#6/Registered Nurse ag but no ambu bag was #5 over to start uld not move him from the because Former Client #5 actical Nurse began Staff#6/Registered Nurse eathing; lurse used a face shield; es of Staff#6/Registered gistered Nurse (RN) based eir respective licenses. with Staff #5 revealed: at shift of 5/2/21 to 5/3/21; et Personnel #1 to complete well as vitals; at #5's room on 5/3/21 at and attempted to arouse him; ient #5's breathing to be	V 218		
	Client #5's room and	lurse returned to Former remained on the phone with			
	Client #5's room and remained on the phone with the 911 operator; -Was directed to retrieve the AED; -Staff#6/Registered Nurse applied the AED to Former Client #5 but no shock was ordered; -Never witnessed Staff#4/Licensed Practical Nurse or Staff#6/Registered Nurse completing CPR as she was directed to the front of the building to await arrival of EMS.				

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CO	MPLETED
			-			
			B. WING			
		MHL036-332	B. WING			7/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
		1089 X F	RAY DRIVE			
FREEDOM	1		NA, NC 28054			
	CLIMMADY CT		·	DDOV/DEDIC DI ANI OF	CORRECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIENC	CY)	
V 218	Continued From nego	22	V 218			
V 210	Continued From page	33	V 210			
	Interview on 6/17/21	with Staff#6/Registered				
	Nurse revealed:					
	-Employed as a Regis	stered Nurse;				
		nt shift of 5/2/21 to 5/3/21;				
	-Holds current certific	ation in American Red				
	Cross CPR;					
	-Staff #5 came to her	on 5/3/21 at approximately				
		rmer Client #5's oxygen				
	saturations were low;					
	-Went to check on Fo					
		nange in color and labored				
	breathing;	.ago co.o. aa .a.cca				
	-Could not arouse Fo	rmer Client #5				
	-Left the room to call					
		lurse remained with Former				
	Client #5 to care for h					
		it #5's breathing was similar				
	to snoring but then hi	<u> </u>				
	•	D, but could not identify who				
	was sent;	D, but could not lacking time				
	•	recommended by the AED;				
		n ambu bag, but could not				
	identify who was sent	-				
	•	e the 911 operator wanted				
	compressions started	'				
		actical Nurse completed				
		ped (because Former Client				
	#5 was too heavy to r					
	-After Staff#6/Registe					
	_					
		aid supplies) twice" she				
		no mask with the first aid				
	supplies;	l				
		lurse completed rescue				
	-	k but did not identify from				
	where the mask came	•				
		were proper supplies at the				
	facility;					
	-Had previously inforr	med the Nurse Practitioners				

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there was a need for a back board in case of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL036-332	B. WING		0-	7/20/2021
					0	12012021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FREEDO	М		AY DRIVE IA, NC 28054			
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	E CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 218	Continued From page	e 34	V 218			
	cardiac arrest resultir -The 911 operator repat least one time duri identify how many time was given by the 911 -"I did not want to continue of the American Report of the American	ng in the need for CPR; corted the need to start CPR ing the 911 call but could not nees the directive to start CPR operator; do nothing" Which support Group Specialist ed Cross National Office in a revealed: delayed in the absence of an atted on a soft surface if the in move the victim from the innel are responsible for rescue breathing for a even in the absence of				
	revealed: -Administration review Former Client #5 on 8 -Had been advised by Clinical Services and there was video surve 30 minute checks bei Client #5 during the co 5/2/21-5/3/21; -Upon request on 6/1 11:15am to provide the incident as well as the illustrating the 30 min completed, the Progre	y the Vice President of Quality Management that eillance footage illustrating ng completed on Former evernight shift of 7/21 at approximately ne report reviewing the e video surveillance footage				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		MHL036-332	B. WING		07	7/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FREEDON	Л		RAY DRIVE			
	T		NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 218	Continued From pag	je 35	V 218			
	surveillance footage					
	Clinical Services and revealed: -An Executive Incide	with the Vice President of d Quality Management ent Review was completed on avolving Former Client #5 and transfer				
	Operations revealed -The Program Direct find the Executive In involving Former Cli -Was on vacation wi not able to provide in Executive Incident R	for was not aware of where to cident Review of the incident ent #5 on 5/3/21; the no cell coverage and was information as to where the deview report was located ed by the Division of Health				
	Operations revealed -There was no video illustrating the 30 mi	surveillance footage nute checks being completed available for review as it was				
	revealed: -Admitted 4/22/21; -Discharged 4/28/21 -Diagnosed with Opi Sedative, Hypnotic, Severe; Cannabis U Stimulant Use Disord Substance; General Sedative, Hypnotic, Use Disorder, Mode	oid Use Disorder, Severe; or Anxiolytic Use Disorder, se Disorder, Severe; der, Mild, Amphetamine-type ized Anxiety Disorder; and or Anxiolytic Intoxication, with				

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	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING			
		MHL036-332	B. WING		07/20	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		1089 Y R	AY DRIVE			
FREEDOM	1					
		GASTON	IA, NC 28054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGOLATORI ORT	EGO IDENTII TIING INI GIAWATIGIV)	TAG	DEFICIENCY)	WAI E	
V 218	Continued From page	e 36	V 218			
	Nurse Practitioner rev	vealed: Medications to be				
	-	cluded Klonopin (alcohol and				
	•	xification protocol) taper				
	•	rith 1mg (milligrams) three				
	•	sed through day six with				
		Iltivitamin (supplement) 1				
	•	(supplement) 100mg on				
		is needed; and Folate				
	, , ,	ily. Medications to be				
		s-needed basis included				
		after meals or at bedtime,				
	Famotidine 20mg twice	•				
	•	hours, Imodium 2mg every				
		ne 10mg every 6 hours, and				
	_	Oml (milliliters) twice daily for				
	•	col; Trazodone 100mg at				
	bedtime for sleep pro	tocol; Ibuprofen 600mg				
	every 6 hours, Acetar	minophen 650mg every 6				
		zaprine 10mg every 6 hours				
	for pain protocol; Gab	papentin 300mg every 6				
	hours and Seroquel 2	25mg every 4 hours for				
	anxiety protocol; and	Benadryl 50mg daily and				
	Cetirizine 10mg daily	for allergy protocol;				
	-No MAR was availab	ole for review.				
	Review on 6/14/21 of	the facility's Incident				
	Reports revealed:					
	-Incident Report date	d 4/24/21 for Former Client				
	#6 regarding an atten	npted diversion of Ativan				
	during medication add	ministration which was				
	observed and preven	ted by the nurse				
	administering the med	•				
	_	d 4/26/21 for Former Client				
		ry of 5 pills on the desk in				
	Former Client #6's roo	·				
		avioral Health Technician and				
		nurse's station and locked.				
		13 3 3				
	Upon request to the F	Program Director on 7/7/21				
	for the facility's Divers					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
			A. BUILDING: _		
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE	
			AY DRIVE	, 2 0002	
FREEDOM	1				
			IA, NC 28054		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
		,		DEFICIENCY)	
V/ 040	10 2		V 240		
V 218	Continued From page	e 37	V 218		
	Program Director sub	mitted a policy entitled			
	Suboxone Diversion I	Plan dated 11/23/09 with			
	revisions and review	on 7/1/10, 8/13/12, and			
	10/28/16. Review on	7/7/21 of the Suboxone			
	Diversion Plan submi	tted for review revealed:			
	-"Program Director	and Clinical Supervisors			
	ensure that all employ	yees follow the provisions of			
	this plan. This includ	es: training employees on			
		plan, enforcing compliance			
	with this plan, ensuring	ng new employees are			
	properly trained on th	e risks of medication			
	diversion and are awa	are of staff and patient			
	responsibilities in pre	venting diversion,			
	performing follow-up	procedure on all medication			
	diversion incidents	employees are to follow all			
	policies and procedur	res relating to diversion			
	control, and perform t	tasks in a manner that			
	minimizes the risk of	medication diversion"			
		nined what pills were located			
		room as there was no			
	documentation regard	ding this information and			
		tion administration record for			
	Former Client #6.				
		Staff #1, #2, #3/Registered			
		Practical Nurse, #5, and			
	•	s training records revealed:			
		g provided on diversion			
	control.				
	Intonuiowe during the	ovit conforance conducted			
	_	exit conference conducted			
		rogram Director, Nurse			
	President of Clinical S	sident of Operations, Vice			
		· ·			
	-	ecutive Vice President			
	revealed:	or roughled Stoff #Ctd			
		er revealed Staff #6 acted			
		lient #6 had a pulse, blood			
	pressure and respirat	ion so CPR should not have			

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					
		MHL036-332	B. WING		07/20/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AT	DRESS, CITY, STA	TE ZID CODE	
TWANE OF TH	TOVIDER OR OUT FIELD			TE, ZII OOBE	
FREEDOM	1		AY DRIVE		
		GASTON	IA, NC 28054		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
				DET TOTEROTY	
V 218	Continued From page	e 38	V 218		
	Commission Fage Co				
	been initiated. CPR is only to be initiated when				
	there is an absence of	f a pulse and blood			
	pressure. Former Cli	ent #5 was still a viable			
	patient. Having starte	ed CPR would have caused			
	-	a viable patient. According			
		ed Cardiovascular Life			
	Support) algorithm for				
	, •	gencies, when the patient			
		normal breathing pattern,			
	•	is to be maintained and			
	rescue breathing is to				
	_				
		President revealed that			
		opriately administered at the			
	facility and per protoc				
		opriately observed. Client			
		ity is voluntary and all			
		taken to avoid diversion.			
		ed and retrained on avoiding			
	diversion of medication	on. Diversion is anticipated			
	by the staff and appro	priate monitoring is in place			
	to prevent diversion.	Acknowledged there was no			
	documentation of obs	ervation of Former Client #5			
	from 12:04am until ap	proximately 5:30am on			
	5/3/21; however, care	ful review of the incident on			
	5/3/21 resulted in faci	lity administration deeming			
		edical incident. All staff			
		ervened and documented			
	appropriately;				
		of Operations revealed			
		checked throughout the			
		of 5/3/21 but there was no			
		30-minute observation			
		ou-minute observation			
	checks;	f Oliminal Committee			
		of Clinical Services and			
		revealed the facility staff			
		n the issues identified during			
	-	ntinue to work aggressively			
	to address all challen	ges.			
			1		

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Review on 6/17/21 of the 1st Plan of Protection

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Division	of Health Service Regu	lation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
		MHL036-332	B. WING		07/20/2021
		077557.1		- 710 000F	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE	
FREEDON	1	1089 X R	AY DRIVE		
INCLUOR	1	GASTON	IA, NC 28054		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-1-)
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
V 218	Continued From page 39		V 218		
	written and signed by the Program Director dated 6/17/21 revealed:				
		on will the facility take to			
		he consumers in your care?			
	Client Supervision/30	minute checks:			
	-Behavioral Health Te	echnicians (BHT) are			
		30 minute checks on all			
	I	or each shift (2 x 12 hour			
		go into effect immediately.			
	During each check, B				
	observation form that				
		behavior and demeanor.			
	Once a BHT complete	es their 30 minute			
	observation, each obs	servation sheet will be			
	signed by BHT and n	urse for each shift.			
	-In addition to BHT 30	Checks, nurse will			
		ry 2 hours and document			
	observation on nursin	-			
		ig observation forms.			
	Diverting Medications	("chooking mode")			
		,			
		y, all client's mouths will be			
		ursing staff during each			
	medication administra				
	medications were swa	allowed and no medications			
	were accessible to cli	ents. Nurse administering			
	medications will sign	off on medication			
		to acknowledge compliance			
		ecking mouth, ensuring			
		orage) to prevent medication			
	diversion.	rage, to prevent inculcation			
	uiveisiuii.				
	CDB Compotonovice	d Training			
	CPR Competency an	_			
	_	ensure that all BHT staff			
		ified by 6/25/21. Prior to			
		fication, Program Director			
	will ensure that there	is a CPR/First Aid certified			
	staff member on site	at all times. Program			
		nat all staff working each			
		on site staff members that			

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are CPR/First Aid certified to ensure timely

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING	B. WING		//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	и		AY DRIVE IA, NC 28054			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
V 218	response in an emerged possible your plans thappens. Client Supervision/30 Director will verbally ibeginning of each ship protocol and will configure to a supervision of the protocol and will configure to a supervision of the program of the progr	minute checks: Program inform all staff at the ft of client supervision irm staff comprehension of all clients with nursing and rvation form after each shift. ("cheeking meds"): //or Director of e will verbally inform all staff ich shift of new protocol and prehension of checking ipliance and proper Program Director, Director arge Nurse will review MARs ration Records) to check for basis. d Training: Program in Director of Performance ining to review staff in need and confirm training dates, completion and staff im Director will communicate embers to all staff at the obtain staff	V 218	DEFICIENC	(Y)	
	written by the Vice Pr 7/20/21 revealed: "What immediate acti ensure the safety of the Facility Leadership will Records at the facility	esident of Operations dated on will the facility take to he consumers in your care?				

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MHL036-332 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)							
FREEDOM 1089 X RAY DRIVE GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			MHL036-332	B. WING		07/2	0/2021
GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	FREEDO	М					
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
V218 Continued From page 41 remotely. Program Director will ensure receipt of all onboardinghew hires requirements including Criminal Background Check, CPR Training date, New Employee Orientation including Client Rights and Confidentiality, Bloodborne Pathogen training, and population specific training. NCI training is now facilitated every Tuesday by the Director of Performance Improvement and Training. New hires will not be permitted to start direct care until they have received certification of training. CPR training now occurs monthly. All new hires will be scheduled for CPR training within the first 30 days of hire. New hires will not be permitted to start direct care until confirmation of CPR training registration, Program Director will ensure CPR training occurs within the first 30 days of hire. Monthly Performance Improvement meetings will be held. These meetings will be a review of safety concerns raised by the staff, review of disaster and fire drills, and review of incidents from the month with root cause analysis. The committee consists of facility level staff - Program Director, nursing staff, lead behavioral health technician, and clinical coordinator. Describe your plans to make sure the above happens. Vice President of Operations will hold weekly supervision with the Program Director and these topics will be reviewed during these meetings. In addition, the Vice President of Operations will review minutes of the monthly Performance Improvement meetings.*	V 218	remotely. Program Diall onboarding/new hi Criminal Background New Employee Orien and Confidentiality, B training, and population training is now facilitated Director of Performant Training. New hires with direct care until they be training. CPR training new hires will be schewithin the first 30 day be permitted to start of CPR training registensure CPR training days of hire. Monthly Performance be held. These meetic concerns raised by the and fire drills, and rewmonth with root cause consists of facility leven ursing staff, lead be and clinical coordinate. Describe your plans thappens. Vice President of Opes supervision with the Ftopics will be reviewe addition, the Vice Prereview minutes of the Improvement meeting. Review on 7/20/21 of written by the Vice President of Opes review on 7/20/21 of written by the Vice President of Vice President	rector will ensure receipt of ires requirements including Check, CPR Training date, tation including Client Rights loodborne Pathogen on specific training. NCI atted every Tuesday by the fine Improvement and will not be permitted to start that the received certification of a now occurs monthly. All eduled for CPR training is of hire. New hires will not direct care until confirmation tration. Program Director will occurs within the first 30. Improvement meetings will ings will be a review of safety the staff, review of disaster wiew of incidents from the ele analysis. The committee ele staff - Program Director, thavioral health technician, or. To make sure the above the erations will hold weekly Program Director and these did during these meetings. In esident of Operations will inconthly Performance gis."	V 218			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		COMPLETED	
			A. BUILDING: _			
		MHL036-332	B. WING		07/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	NOVIDER OR GOLT EIER			12, 211 0052		
FREEDOM	Λ		AY DRIVE			
		GASTON	IA, NC 28054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	, ,	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
170		,	IAG	DEFICIENCY)		
V 249	18 Continued From page 42		V 249			
V 218	Continued From page 42		V 218			
	ensure the safety of the	he consumers in your care?				
	Facility Leadership wi	ill maintain Personnel				
	Records at the facility	level. This is a change from				
	Corporate HR (Huma	n Resources) Team				
	managing personnel	files remotely. Program				
	Director will ensure re	eceipt of all onboarding/new				
	hires requirements in	cluding Criminal				
	Background Check, F	lealth Care Personnel				
	Registry, CPR Training	ng date, New Employee				
	Orientation including	Client Rights and				
	Confidentiality, Blood	borne Pathogen training,				
	and population specif	ic training. NCI (North				
	Carolina Interventions	s) training is now facilitated				
	every Tuesday by the	Director of Performance				
	Improvement and Tra	ining. New hires will not be				
	permitted to start dire	ct care until they have				
		of training. CPR training				
	now occurs monthly.					
		aining within the first 30 days				
		not be permitted to start				
		mation of CPR training				
		Director will ensure CPR				
		the first 30 days of hire.				
	•	e effective immediately for				
		current staff personnel				
		ated from the Corporate				
	personnel files by 8/6	/21.				
	Nursing staff maintain	n medication administration				
	_	anner however the survey				
	I	Medication Administration				
	_					
		before the paper chart is				
	Record) had not been properly scanned into the selected client chart upon discharge. A new protocol was implemented on 6/21/21 to ensure that the discharge nurse audits the chart (including the MAR) at the time of discharge, a BHT (Behavioral Health Technician) staff member uploads the chart and MAR to the electronic medical record, and the Program Director audits					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		MHL036-332	B. WING		07/20/2021	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	1 0112	.0/2021
NAIVIL OI I	KOVIDEK OK 301 1 EIEK	1089 X RA		II., ZII GODE		
FREEDOM	1		, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETE DATE
V 218	Continued From page 43		V 218			
	shredded.					
	A new protocol for documenting client supervision by BHT and nursing staff was implemented on 6/21/21. This new protocol reinforced the expectation that BHT staff are expected to conduct 30 minute checks on all clients in the facility for each shift (2 x 12 hours shifts/day). Each BHT now completes an observation form that documents BHT observations of client behavior and demeanor. Once a BHT completes their 30 minute observation, each observation sheet will be signed by the BHT and a nurse for each shift. In addition to the 30 minute BHT checks, on 6/21/21, nurses began completing rounds every 2 hours and documenting their observations on a nursing observation form. BHT staff will be retrained by 7/23/21 to ensure that vitals are recorded every four hours for the first 24 hours of a client's admission. Documentation of training will be maintained in					
	be held, with the first These meetings will be	e Improvement meetings will meeting held by 8/6/21. De a review of safety De staff, review of disaster				
	and fire drills, and rev	view of incidents from the e analysis. The committee				
		el staff - Program Director,				
	nursing staff, lead bel	havioral health technician,				
	and clinical coordinate	or.				
	Describe your plans to make sure the above happens. Vice President of Operations will hold weekly supervision with the Program Director and these					
		d during these meetings. In				
		esident of Operations will				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWIDEN.	A. BUILDING: _		COMITEE	ILD
		MHL036-332	B. WING		07/20	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
FREEDO	И		AY DRIVE IA, 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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CTION SHOULD BE COMPLI O THE APPROPRIATE DATE	
V 218	review minutes of the Improvement meeting. Clients #1 and #2 and and #6 were diagnose polysubstance abuse facility for detoxification #5 had additional meincluding Bipolar Disorder. Former Client #5 did and care required. House the facility protocous observe and docume and status every thirt documentation of such 12:04am when vitals approximately 5:30ar unresponsive in his relabored breathing and nursing staff assessific contacting 911, there minutes prior to seculand initiating emerge. Facility staff did not reto provide required care former Clients #3, #4 training in substance including delirium trees secondary complication understanding the nawithdrawal syndrome therapy, and other tree Additional gaps in trageneral organizations.	e monthly Performance gs." d Former Clients #3, #4, #5 ed with alcohol and/or and were admitted to the on. Former Clients #4 and intal health diagnoses order, Attention Deficit er, and Generalized Anxiety not receive the monitoring e reportedly took Subutex. col and medical orders to intithe clients' whereabouts y minutes, there was no chimonitoring on 5/3/21 from were last recorded until in when he was found boom, blue in color, with id low pulse oximetry. Upon ing Former Client #5 and was a delay of over 7 ring necessary equipment incy care. eceive the necessary training are to Clients #1 and #2 and 4, #5, and #6. There was no abuse withdrawal symptoms mens, symptoms of ons to substance abuse,	V 218			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SI COMPLE	
		MHL036-332	B. WING		07/2	0/2021
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		1 0772	0/2021
NAME OF PI	ROVIDER OR SUPPLIER		AY DRIVE	TE, ZIP CODE		
FREEDON	I		IA, NC 28054			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 218	there was a lack of transtrictive intervention restraint, and isolation. Facility staff did not make the control of the contro	orne pathogens. Finally, aining in alternatives to a, seclusion, physical an time-out. Inonitor and record each bry four hours for the first 24 did not completed the port. Additionally, no ation record was maintained making it impossible to ations received while at the atrol protocol was not an er Clients #5 and #6. For enot maintained resulting ription for the Licensed and it impossible to determine ailities and chain of ally, continuing education for an ursing staff was not an er cardiopulmonary remore, contracted were used at the facility tation of training, education, aground checks. It tutes a Type A1 rule arm and neglect and must a days. An administrative is imposed. If the violation is 3 days, an additional of \$500.00 per day will be at the facility is out of	V 218	DELIGITION OF THE PROPERTY OF		
V 219	compliance beyond the 27G .3102 Nonhospit 10A NCAC 27G .3102	al Med. Detox Staff	V 219			

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING			
		MHL036-332	B. WING		07/	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	TE, ZIP CODE		
FREEDON	I		AY DRIVE			
			IA, NC 28054			
(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 (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
V 219	9 Continued From page 46		V 219			
	(a) A minimum of one direct care staff member shall be on duty at all times for every nine or fewer clients. (b) The treatment of each client shall be under the supervision of a physician. (c) The services of a certified alcoholism counselor, a certified drug abuse counselor or a certified substance abuse counselor shall be available to each client. (d) Each facility shall have at least one staff member on duty at all times trained in the following areas: (1) substance abuse withdrawal symptoms, including delirium tremens; and (2) symptoms of secondary complications to substance abuse. (e) Each direct care staff member shall receive continuing education to include understanding of the nature of addiction, the withdrawal syndrome, group therapy, family therapy and other treatment methodologies. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure training in substance abuse withdrawal symptoms including delirium tremens, symptoms of secondary complications to substance abuse, understanding the nature of addiction, the withdrawal syndrome, group therapy, family therapy, and other treatment methodologies affecting 6 of 6 audited staff (Staff #1, #2, #3/Registered Nurse, #4/Licensed Practical Nurse, #5, and #6/Registered Nurse) and 1 of 1 audited contract personnel (Contract Personnel #1). The findings are:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		MHL036-332	B. WING		07	//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
FREEDOM	И		AY DRIVE			
	I		IA, NC 28054			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 219	Commission Page 17		V 219			
	-No training in substa symptoms including of of secondary complic understanding the na withdrawal syndrome	oral Health Technician; nce abuse withdrawal lelirium tremens, symptoms ations to substance abuse, ture of addiction, the , group therapy, family eatment methodologies.				
	Review on 6/17/21 of Staff #2's record revealed: -Hired 12/7/20; -Employed as Behavioral Health Technician; -No training in substance abuse withdrawal symptoms including delirium tremens, symptoms of secondary complications to substance abuse, understanding the nature of addiction, the withdrawal syndrome, group therapy, family therapy, and other treatment methodologies.					
	record revealed: -Hired 8/17/20; -Employed as Registe -No training in substa symptoms including o of secondary complic understanding the na withdrawal syndrome	nce abuse withdrawal lelirium tremens, symptoms ations to substance abuse,				
	Nurse's record reveal -Hired 3/8/21; -Employed as License -No training in substa symptoms including o of secondary complic understanding the na withdrawal syndrome	ed Practical Nurse; nce abuse withdrawal lelirium tremens, symptoms ations to substance abuse,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPLI			E SURVEY PLETED	
		MHL036-332	B. WING		07	7/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	•	
			RAY DRIVE	,		
FREEDON	Л	GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 219	Continued From pag	ge 48	V 219			
	-Hired 4/15/21; -Employed as Beha -No training in subst symptoms including of secondary compli understanding the n withdrawal syndrom therapy, and other to Review on 6/17/21 or record revealed: -Hired 3/1/21; -Employed as Regis -No training in subst symptoms including of secondary compli understanding the n withdrawal syndrom therapy, and other to Review on 7/9/21 of the Program Director -The facility had use	tance abuse withdrawal delirium tremens, symptoms ications to substance abuse, ature of addiction, the e, group therapy, family reatment methodologies. The email correspondence from the product of the contracted and agencies from 1/1/21				
	Administrator and a Personnel #1's reco	rd available for review;				
	Personnel #1's job r experience, and qua Resources Administ Personnel #1 worke Technician. There w	details regarding Contract responsibilities, training, alifications, the Human rator revealed Contract d as a Behavioral Health vere no records maintained nel #1 as she was not an				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
FREEDON	Л	1089 X RA GASTONIA	Y DRIVE A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE
V 219	Operations revealed: -No longer using cont agencies to provide si-Recognized deficits vin a lack of training for Technicians; -Recently implemented Interviews during the on 7/20/21 with the Propartitioner, Vice President of Clinical Simplement, and Extrevealed: -The Vice President of Quality Management detection of the gaps protocol as it relates the delivery of services. The deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the deficiency is cross NCAC 27G .3101 Scotnicials of the same protocol as it relates the same pro	ry but was contracted rough a contracted agency. with the Vice President of racted healthcare personnel taffing for the facility; with training which resulted rethe Behavioral Health and a new training system. exit conference conducted rogram Director, Nurse sident of Operations, Vice Services and Quality ecutive Vice President f Clinical Services and	V 219		
V 220	10A NCAC 27G .3103 (a) Monitoring Clients written policy that required (1) procedures general condition and	s. Each facility shall have a	V 220		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING	B. WING		//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	и		AY DRIVE IA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 220	recording each client' and temperature at le first 24 hours and at le thereafter. (b) Discharge Planni Treatment/Rehabilitat discharging the client discharge plan for each client who has comple	for monitoring and s pulse rate, blood pressure ast every four hours for the east three times daily	V 220			
	failed to monitor and rate, blood pressure, every four hours for the of 2 audited current cand 4 of 4 audited for #3, #4, #5, and #6) and discharge plan for 1 of (Former Client #5).	and record review, the facility record each client's pulse and temperature at least the first 24 hours affecting 2 lients (Clients #1 and #2) mer clients (Former Client and failed to complete a sudited former Clients the findings are:				
	-"Vitals will be take 24 hours after a patie will be taken every 6 leview on 6/17/21 ar record revealed: -Admitted 6/8/21; -Diagnosed with Alcole-Vitals were not taken	n every 4 hours for the first nt admits. Thereafter, vitals				

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DIVISION	n nealth Service Negu	ialion	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
						
		MHL036-332	B. WING		07/20)/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AS	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER			KIE, ZIP CODE		
FREEDOM 1089 X RA						
		GASTON	A, NC 28054			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
V 220	Continued From page	51	V 220			
	Continued From page	, 01	1			
	at 11:54am and 4:58p	om and on 6/9/21 at				
	11:50am).					
	Review on 6/17/21 ar	nd 7/7/21 of Client #2's				
	record revealed:					
	-Admitted 6/11/21;					
		hol Use Disorder, Severe;				
	Cannabis Use Disord					
		every four hours during the				
		ment (vitals taken on 6/11/21				
		2/21 at 12:43am, 6:09am,				
	12:46pm, and 6:18pm					
	12.40pm, and 6.10pm	1).				
	Davious on 6/17/21 on	ad 7/7/21 of Former Client				
		nd 7/7/21 of Former Client				
	#3's record revealed:					
	-Admitted 6/3/21;					
	-Discharged 6/9/21;					
		hol Use Disorder, Severe;				
		every four hours during the				
		ment (vitals taken on 6/3/21				
	at 10:48pm and 11:18	•				
	2:18am, 6:30am, 11:4	17am, and 5:46pm).				
	Review on 6/17/21 ar	nd 7/7/21 of Former Client				
	#4's record revealed:					
	-Admitted 4/30/21;					
	-Discharged 5/7/21;					
		hol Use Disorder, Severe;				
		r Anxiolytic Use Disorder,				
	Severe; Attention Deficit Hyperactivity Disorder; Generalized Anxiety Disorder;					
		every four hours during the				
		ment (vitals taken on 4/30/21				
		11:31pm, 11:36pm and				
	5/1/21 at 5:39am, 12:					
	5/1/21 at 5.59am, 12:	zopin, and 5.49pm).				
	Daview ex 0/47/04	4 7/7/04 of Fames Oli t				
		nd 7/7/21 of Former Client				
	#5's record revealed:					
	-Admitted 5/1/21;					

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-Discharged 5/3/21;

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STATEMENT OF DEPICIPACIES AND PLAN OF CORRECTION MHL036-332 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE 1089 X RAY DRIVE GASTONIA, NC 20854 MRL036-332 DI PROVIDER'S ILAN OF CORRECTION (CASTONIA), NC 20854 OVA; ID SUMMARY STATEMENT OF DEPICIENCIES (PART IN A CONTROLL) (CROSS REPERCISED A) FAIL. PROVIDER'S ILAN OF CORRECTION (CROSS REPERCISED A) FAIL. PRETOX (CROSS REPERCISED A) FAIL	Division	of Health Service Regu	lation			
MHL038-332 MHL038-332 STREET ADDRESS, CITY, STATE, ZIP CODE				(X2) MULTIPLE	CONSTRUCTION	
INMIC OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 20044 (PAYLO) REETIX TAG CONTINUED FROM SUMMARY STATEMENT OF DEFICIENCIES (FACH) DEFICIENCY MUST RE PERCEDED BY PLILL TAG CROSS-REFERENCE TO THE APPROPRIATE (FACH) DEFICIENCY ON THE DEFICIENCIES (FACH) DEFICIENCY MUST RE PERCEDED BY PLILL TAG CROSS-REFERENCED TO THE APPROPRIATE (PAYLO) CONTINUED FROM THE APPROPRIATE (PAYLO) CROSS-REFERENCED TO THE APPROPRIATE CONTECT TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFE	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
NAME OF PROVIDER OR SUPPLIER SIRRET ADDRESS, CITY, STATE, ZIP CODE 1888 X RAY DRIVE GASTONIA, NC 28054 (X4) ID PREFIX TAG CROSS REFERENCE CLOSE CONTINUES TRANSPORTED THAT OF CORRECTION (CASTONIA) CONTINUES TO THAT OF CONTINUES TO THAT OF CORRECTION (CASTONIA) CONTINUES TO THAT OF CONTINUES TO T						
NAME OF PROVIDER OR SUPPLIER TREEDOM SUMMARY STATEMENT OF GERCIENCES GASTONIA, NC 28954 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF GERCIENCES SUMMARY STATEMENT OF GERCIENCES SUPPLIES SEARCH SERVINGS ON WIST OF PROCESSED BY THAIL PREFIX SEARCH SERVINGS ON WIST OF PROCESSED BY THAIL RESULATORY OR LSC IDENTIFYING INFORMATION) V 220 Continued From page 52 -Diagnosed with Alcohol Use Disorder, Severe; Opioid Use Disorder, Severe in Sustained Remission; Stimulant Use Disorder, Severe in Sustained Remission; Bipolar II Disorder, Other Personal History of Psychological Trauma; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 57/121 at 8:22pm and 9:41pm and on 57/221 at 12:32am, 6:24am, 12:17pm and 6:21pm); -No discharge summary available for review. Review on 6/14/21 of the facility's Discharge Client List revealed: -Former Client #5 was not identified on the list. Review on 7/7/21 of Former Client #6's record revealed: -Admitted 4/22/21; -Discharged 4/28/21; -Diagnosed with Opioid Use Disorder, Severe; Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe; Cannabis Use Disorder, Severe; Stimulant Use Disorder, Midi, Amphetamine-type Substance; Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder, Moderate or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hirred 3/19/21; -Employed as Behavioral Health Technician.			MHI 036-332	B. WING		07/20/2024
Transport Tran			WITILU30-332			1 0112012021
CASTONIA, NC 28054 CASTONI	NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES PROVIDENS PLAN OF CORRECTION PREFIX TAG PROVIDENS PLAN OF CORRECTION PREFIX TAG		_	1089 X F	AY DRIVE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 220 Continued From page 52 -Diagnosed with Alcohol Use Disorder, Severe; Opioid Use Disorder, Severe in Sustained Remission; Stimulant Use Disorder, Gevere in Sustained Remission; Biploar II Disorder, Attention Deficit Hyperactivity Disorder; Other Personal History of Psychological Trauma; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 5/1/21 at 8:22m and 94 plm and on 5/22/1 at 12:32am, 6:24am, 12:17pm and 6:21pm); -No discharge summary available for review. Review on 6/14/21 of the facility's Discharge Client List revealed: -Former Client #5 was not identified on the list. Review on 7/7/21 of Former Client #6's record revealed: -Admitted 4/22/21; -Discharged 4/28/21; -Diagnosed with Opioid Use Disorder, Severe; Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe; Stimulant Use Disorder, Mild, Amphetamine-type Substance; Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder, Moderate or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/22/21 at 5:36am, 12:16pm, 5:32pm and 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.	FREEDON	ı	GASTON	IIA, NC 28054		
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V 220 Continued From page 52 -Diagnosed with Alcohol Use Disorder, Severe; Opiold Use Disorder, Severe in Sustained Remission; Stimulant Use Disorder, Gevere in Sustained Remission; Bipolar II Disorder, Attention Deficit Hyperactivity Disorder, Other Personal History of Psychological Trauma; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 57/121 at 8:22pm and 9:41pm and on 5/2/21 at 12:32am, 6:24am, 12:17pm and 6:21pm); -No discharge summary available for review. Review on 6/14/21 of the facility's Discharge Client List revealed: -Former Client #6's record revealed: -Admitted 4/22/21; -Discharged 4/28/21; -Diagnosed with Opioid Use Disorder, Severe; Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe; Cannabis Use Bisorder, Severe; Stimulant Use Disorder, Mild, Amphetamine-type Substance, Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder, Moderate or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/22/21 at 5:36am, 12:16pm, 5:32pm and 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.						()
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Remission; Stimulant Use Disorder, Severe in Sustained Remission; Bjolar II Disorder, Attention Deficit Hyperactivity Disorder; Other Personal History of Psychological Trauma; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 5/1/21 at 8:22pm and 9:41pm and on 5/2/21 at 12:32am, 6:24am, 12:17pm and 6:21pm); -No discharge summary available for review. Review on 6/14/21 of the facility's Discharge Client List revealed: -Former Client #5 was not identified on the list. Review on 7/7/21 of Former Client #6's record revealed: -Admitted 4/22/21; -Discharged 4/28/21; -Discharged 4/28/21; -Discharged 4/78/21; -Diagnosed with Opioid Use Disorder, Severe; Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe; Stimulant Use Disorder, Mild, Amphetamine-type Substance, Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder fixed Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder fixed Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder fixed Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder fixed Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder fixed Anxiety Disorder; and Sedative, Hypnotic, or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/22/21 at 5:36am, 12:16pm, 5:32pm and 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.						
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-Discharged 4/28/21; -Diagnosed with Opioid Use Disorder, Severe; Sedative, Hypnotic, or Anxiolytic Use Disorder, Severe; Cannabis Use Disorder, Severe; Stimulant Use Disorder, Mild, Amphetamine-type Substance; Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder, Moderate or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/22/21 at 5:36am, 12:16pm, 5:32pm and 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.						
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Substance; Generalized Anxiety Disorder; and Sedative, Hypnotic, or Anxiolytic Intoxication, with Use Disorder, Moderate or Severe; -Vitals were not taken every four hours during the first 24 hours of treatment (vitals taken on 4/22/21 at 5:36am, 12:16pm, 5:32pm and 4/23/21 at 1:02am and 5:46am). Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.						
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Review on 6/17/21 of Staff #1's record revealed: -Hired 3/19/21; -Employed as Behavioral Health Technician.		· ·				
-Hired 3/19/21; -Employed as Behavioral Health Technician.		·				
-Hired 3/19/21; -Employed as Behavioral Health Technician.						
-Employed as Behavioral Health Technician.			Stan #1's record revealed:			
Review on 6/17/21 of Staff #2's record revealed:		-∟mployed as Behavi	oral Health Technician.			
Review on 0/17/21 of Staff #2's record revealed.		Daviou on 6/47/04 -4	Stoff #2's record revealed:			
			Stall #28 record revealed:			
-Hired 12/7/20; -Employed as Behavioral Health Technician.			ioral Health Technician			

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COWII LETED
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
FREEDON	1	1089 X RA			
			A, NC 28054		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 220	Continued From page	e 53	V 220		
	Review on 6/17/21 of Staff #3/Registered Nurse's record revealed: -Hired 8/17/20; -Employed as Registered Nurse. Interview on 6/16/21 with Staff #1 revealed: -Responsible for taking vital signs every 6 hours or twice per 12 hour shift.				
		with Staff #2 revealed: ng vitals every 6 hours.			
	Interview on 6/16/21 Nurse revealed: -Vital signs are taken	with Staff #3/Registered every 6 hours.			
	Interview on 6/18/21 with the Discharge Planner/Coordinator revealed: -There was no discharge summary completed on Former Client #5 because he was not discharged from the facility but was transferred from the facility due to a medical emergency.				
	on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S Management, and Ex revealed: -Nurse Practitioner re provided to all Behav Nurses to complete v	exit conference conducted rogram Director, Nurse sident of Operations, Vice Services and Quality secutive Vice President evealed training had been ioral Health Technicians and ital signs every four hours of treatment. Will retrain the			
	NCAC 27G .3101 Sco	The deficiency is cross referenced into 10A NCAC 27G .3101 Scope (V218) for a Type A1 rule violation and must be corrected within 23			

Division of Health Service Regulation

STATE FORM 6899 1W3911 If continuation sheet 54 of 76

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	
		MHL036-332	B. WING		07/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
FREEDOM	FREEDOM 1089 X RA GASTONI					
(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	(X5) COMPLETE DATE
V 512	Continued From page 54		V 512			
V 512	2 27D .0304 Client Rights - Harm, Abuse, Neglect		V 512			
	(a) Employees shall abuse, neglect and exwith G.S. 122C-66. (b) Employees shall sort of abuse or negle 27C .0102 of this Chack (c) Goods or services purchased from a clie established governing (d) Employees shall necessary to repel or aggressive client and governing body policy is necessary depends characteristics of the and physical and mer of aggressiveness disintervention procedur Subchapter 10A NCA (e) Any violation by a	protect clients from harm, exploitation in accordance and subject a client to any ect, as defined in 10 A NCAC apter. Is shall not be sold to or ent except through goody policy. It is easily that degree of force secure a violent and which is permitted by the degree of force that is upon the individual client (such as age, size ental health) and the degree explayed by the client. Use of es shall be compliance with an employee of Paragraphs Rule shall be grounds for				
	audited staff (Staff#6/subjected 1 of 4 audit	nd record review, 1 of 6				
	Review on 6/17/21 of record revealed: -Hired 3/1/21; -Employed as Registe	Staff#6/Registered Nurse's ered Nurse.				

Division of Health Service Regulation

STATE FORM 6899 1W3911 If continuation sheet 55 of 76

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER ***TATEMENT OF DEFICIENCES** **AND PLAN OF CORRECTION** ***MHL036-332** ***MHL036-332** ***MHL036-332** ***MHL036-332** ***MHL036-332** ***MHL036-332** ***TREET ADDRESS. CITY, STATE, ZIP CODE** ***TODE** **TODE** ***TODE** **TODE** ***TODE** **TODE** ***TODE** **	Division	of Health Service Regu	liation				
MHL036-332 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 28054				(X2) MULTIPLE	CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_ZIP CODE 1088 X RAY DRIVE GASTONIA, NC 28054 (ASTONIA, NC 28054 (AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_ZIP CODE 1088 X RAY DRIVE GASTONIA, NC 28054 (ASTONIA, NC 28054 (
NAME OF PROVIDER OR SUPPLIER 1889 X RAY DRIVE GASTONIA, NC 28954 (A) (D) (PRETIX) (PRETIX			MHL036-332	B. WING		07/2	20/2021
CASTONIA, NO 28054 CASTONI	NAME OF D		OTDEET A		TE 7/D CODE		
CASTONIA, NC 28054 CASTONIA PROPERTIES CACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CHOSS-ARE-PRINCIPLY ACTION SHOULD BE CHOSS-ARE-PRINCIPLY ACTION SHOULD BE CHOSS-ARE-PRINCIPLY APPROVIPED IT DAYS	NAME OF PI	ROVIDER OR SUPPLIER		, ,	ATE, ZIP CODE		
MAI D PREFIX PROVIDENCE STATEMENT OF DEPICISACIES PREFIX PROVIDENCE STATE OF CORRECTION COMPLETE DATE	FREEDOM	1					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 55 Review on 6/17/21 and 7/7/21 of Former Client #5's record revealed: -Admitted 5/1/21; -Discharged 5/3/21; -Discharged 5			GASTON	IIA, NC 28054			T
V 512 Continued From page 55 Review on 6/17/21 and 7/7/21 of Former Client #5's record revealed: -Admitted 5/1/21; -Discharged 5/3/21; -Discharg							
Review on 6/17/21 and 7/7/21 of Former Client #5's record revealed: -Admitted 5/1/21; -Discharged 5/3/21; -Disgnosed with Alcohol Use Disorder, Severe; Opioid Use Disorder, Severe in Sustained Remission; Stimulant Use Disorder, Severe in Sustained Remission; Bipolar II Disorder, Attention Defict Hyperactivity Disorder, There is a sustained Remission; Bipolar II Disorder, Attention Defict Hyperactivity Disorder, Other Personal History of Psychological Trauma; -Nursing note documented as written on 5/3/21 at 5:02am by Staff#6/Registered Nurse revealed: "Pt (Patient) day 2 of 7 of CIWA (Clinical Institute Withdrawal Assessment) protocol for alcohol. Alert and oriented x4. Noted isolated to self relaxing in bed. c/o (complaining of) moderate-severe anxiety and sweating. Mild tremor and moderate restless and agitation observed. Last CIWA 17. Medicated per protocol. Positive effect. Pt observed sleeping throughout night without any further disturbances related to withdrawal;" -Nursing note documented as written on 5/3/21 at 6:08am by Staff#6/Registered Nurse revealed: "Approx (approximately) 5:15am BHT (Behavioral Health Technician) on duty came to nurses station notifying me that pulse ox (oximetry) was in 40-50 range. Went in to assess patient and patient was blue in color, labored breathing and pulse ox 34. Unable to arouse. 911 called, defibrillator applied, advised not to shock, chest compressions started until EMS (Emergency Medical Services) agrired. EMS administered NARCAN. EKG (electrocardiogram) applied, AMBU bag applied with 02 (oxygen). No effect, no change in		•					
Review on 6/17/21 and 7/7/21 of Former Client #5's record revealed: -Admitted 5/1/21; -Discharged 5/3/21; -Diagnosed with Alcohol Use Disorder, Severe; Opioid Use Disorder, Severe in Sustained Remission; Stimulant Use Disorder, Severe in Sustained Remission; Bipolar II Disorder, Attention Deficit Hyperactivity Disorder, Other Personal History of Psychological Trauma; -Nursing note documented as written on 5/3/21 at 5:02am by Staff#6/Registered Nurse revealed: "	170		,	IAG			
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patient. Notified NP (Nurse Practitioner) on call.			•				
Patient transferred to hospital 5:55am;"							

Division of Health Service Regulation

STATE FORM 6899 1W3911 If continuation sheet 56 of 76

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	
			A. BUILDING: _		
		MHL036-332	B. WING		07/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
FREEDON	Λ	1089 X RA	Y DRIVE		
FREEDON	"	GASTONIA	A, NC 28054		
(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 APPROP DEFICIENCY)	BE COMPLETE
V 512	2 Continued From page 56		V 512		
	-Nursing note documented as written on 5/3/21 at 7:16am by Staff#6/Registered Nurse revealed: "Vitals as per BHT on duty at approx. 5:00am during assessments bp (blood pressure) 110/44, pulse 64, respirations 16, saO2 (oxygen saturation) 47, Temperature 96.9"				
	5:15am for Former Ci Staff#4/Licensed Prad Tech (Behavioral He came to the nurse's s that the patient had a The nurse (Staff#6/Re station immediately to other nurse (Staff#4/L duty accompanied the (Staff#6/Registered N his stomach with his I He was not responsive nurse (Staff#6/Regist while the other nurse Nurse) stayed behind arouse the patient. T	d 5/3/21 at approximately lient #5 written by ctical Nurse revealed: " ealth Technician - Staff #5) tation to let the nurse know n oxygen saturation of 47. egistered Nurse) left the passess the patient and the cicensed Practical Nurse) on the first nurse lurse). Patient was found on the ead facing to the left side. We to verbal cues. First ered Nurse) left to call 911, (Staff#4/Licensed Practical and continued to try to the patient was still			
	tech to grab the defib tech came back to the nurse (Staff#6/Regist the room with EMS (E Services) on the phor (Staff#4/Licensed Pra ambu bag to try to ox ambu bag could not be nurse on the phone w Nurse) applied to the advised at that time.	actical Nurse) instructed the rillator from the wall. The eroom with the The first ered Nurse) came back to Emergency Medical ne while the other nurse actical Nurse) left to get an aygenate the patient. The be located at the time. The with EMS (Staff#6/Registered patient and no shock was			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	EIED
		MHL036-332	B. WING		07/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
FREEDON	Λ	1089 X RA				
	I	GASTONIA	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512	2 Continued From page 57		V 512			
	nurse (Staff#4/Licens CPR (cardiopulmonal second nurse (Staff#4/began compressions (Staff#6/Registered Non patient. CPR contand took over the scenario patient with continued to assess tand an EKG. No infowere provided to the was then loaded onto transported to the host communications Call dated 5/3/21 at 5:23:0 Client #5 revealed: -The caller on the 911 Staff#6/Registered No-Staff#6/Registered No-Staff#6/Registere	ed Practical Nurse) to begin ry resuscitation). The 4/Licensed Practical Nurse) while the first nurse lurse) gave mouth to mouth inued until the EMS arrived one. EMS administered in no effect and then the patient, perform vitals, rmation for those results nursing staff. The patient the stretcher and spital via ambulance" the local county's Police for Service Detail Report 03am regarding Former				
	local county's emerge 5:23:03am regarding -The caller for the 91' Staff#6/Registered Nr -Staff#6/Registered Nr +5's "pulse ox was breathwe can't around -At 1 minute and 16 soperator inquired if content of the staff#6/Registered Nr -At 1 minute and 26 soperator inquired if the staff#6/Registered no;"	lurse; lurse reported Former Client all the way downshallow use himcolor is blue;" econds into the call, the 911 ompressions had started and urse replied "No;" econds into the call, the 911 ere was adequate air flow ad Nurse replied "Not much,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		FIED
		MHL036-332	B. WING		07/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	_	1089 X RA	Y DRIVE			
FREEDON	Λ	GASTONI	A, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 512	Continued From page 58		V 512			
	At 2 minutes and 30	seconds into the call, the				
		a defibrillator was available				
	T	ed Nurse replied "Yes, I'll get				
	one;"	ou Muise replied Tes, Til get				
	-At 2 minutes and 50	seconds into the call.				
		urse asked for a defibrillator				
	and directed someon					
		econds into the call, the 911				
operator asked again about a defibrillator and there was no answer from Staff#6/Registered						
	Nurse;					
	-At 3 minutes and 20	seconds into the call, the				
		gain about the defibrillator				
		ns to Staff#6/Registered				
	Nurse on how to use					
		seconds into the call, the				
	defibrillator was analy	_				
		seconds into the call, the				
		o shock recommended;				
		econds into the call, the 911				
		taff#6/Registered Nurse to nd check the airway and				
	throat to ensure they					
	1	seconds into the call, the				
		the patient could be moved				
		ff#6/Registered Nurse				
	advised he was too h	•				
		seconds into the call, the				
	911 operator asked S	taff#6/Registered Nurse if				
	she was ready to com	nplete compressions;				
	-At 5 minutes and 54	seconds into the call,				
	Staff#6/Registered Nurse advised the 911 operator that compressions had not been initiated because they were looking for an ambu bag;					
		seconds into the call the				
		that she really wanted chest				
	compressions begun;					
		seconds into the call, the				
	· · · · · · · · · · · · · · · · · · ·	to start compressions and				
	∣ began giving instructi	ons on how to complete				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL036-332	B. WING	B. WING		7/20/2021
		MITLU36-332			07	120/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FREEDO	И		RAY DRIVE			
		GASTON	NIA, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 512	compressions; -At 7 minutes and 15 compressions were s background was simi moving sporadically g manner. Interview on 6/8/21 w revealed: -Was a client at the fa alcohol detox; -Did not recall getting hospital while a client -Received Subutex fr 5/2/21 at approximate the effects of the Sub gave him a second S -Former Client #4 had facility at admission; -Began profuse sweat second Subutex and happening to him so and went unconscious -Had a previous hero	seconds into the call, the tarted. Noise in the lar to that of bed springs giving way in a rhythmic with Former Client #5 acility in May, 2021 for y sick and going to the at the facility; om Former Client #4 on ely 10-11pm but did not feel outex so Former Client #4 ubutex to take; d snuck 7 Subutex into the lating after he took the felt as if something bad was the wrote the serenity prayer s; in overdose in 2018 and he ring the previous overdose	V 512			
	Subutex from Former Client #4; -Never reported the incident of taking Former Client #4's Subutex to anyone at the facility; -Had been administered many pills at the facility;					
	medication administrations ome of the pills; -Was administered at the first day of treatm medications for the refacility; -Former Client #5 training.	not really watch him during ation so it was easy to hide and took Klonopin and Ativan ent and then "cheeked" the emainder of his time at the ded his "cheeked" Klonopin				
		for Former Client #4's ent #5 provided Former				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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			B WING			
		MHL036-332	B. WING		07/2	0/2021
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TO WILL OF TH	NOVIBER OR GOLF EIER			(12, 211 GGBE		
FREEDOM	Λ		AY DRIVE			
		GASTON	IIA, NC 28054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	KIATE	DATE
				52116.211617		
V 512	Continued From page	e 60	V 512			
		onopin and Former Client #4				
	provided Former Clie	nt #5 two Subutex).				
	Interview on 6/17/21	with Staff#6/Registered				
	Nurse revealed:					
	-Employed as a Regis	stered Nurse;				
	-Holds current certific	ation in American Red				
	Cross CPR;					
	-When asked to provi	ide a CPR certification card				
		Staff#6/Registered Nurse left				
		nd returned with a CPR card				
		ification in CPR through the				
		dated 8/16/19 valid for two				
	years;	dated of 10/10 valid for two				
		nt shift of 5/2/21 to 5/3/21;				
		on 5/3/21 at approximately				
	-	rmer Client #5's oxygen				
	saturations were low;					
	-Went to check on Fo					
		nange in color and labored				
	breathing;					
	-Could not arouse Fo					
	-Left the room to call	•				
		lurse remained with Former				
	Client #5 to care for h					
		nt #5's breathing was similar				
	to snoring but then hi	- · · · · · · · · · · · · · · · · · · ·				
	-Someone got an AEI	D (Automated External				
	Defibrillation), but cou	uld not identify who was				
	sent;					
	-There was no shock	recommended by the AED;				
	-Sent someone for ar	n ambu bag, but could not				
	identify who was sent					
		e the 911 operator wanted				
	compressions started	•				
	I	actical Nurse completed				
		ped (because Former Client				
	#5 was too heavy to r	•				
	-After Staff#6/Registe					
	urrough the bag (first	aid supplies) twice" she				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPLE	ובט
		MHL036-332	B. WING		07/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FREEDON	Л	1089 X RA				
	OLIMAN DV OT		A, NC 28054	DDOWNERS DIAN OF CORRECTION	- I	
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 512	Continued From page	e 61	V 512			
	discovered there was supplies; -Staff#6/Registered Noreathing with a mask where the mask came. Did not believe there facility; -Had previously informathere was a need for cardiac arrest resulting. The 911 operator regat least one time during identify how many time was given by the 911"I did not want to continue the supplies of the supplies o	Jurse completed rescue k but did not identify from e; were proper supplies at the med the Nurse Practitioners a back board in case of ag in the need for CPR; corted the need to start CPR and the 911 call but could not nees the directive to start CPR operator; do nothing"				
	Interview on 7/8/21 with Support Group Specialist from the American Red Cross National Office located in Pennsylvania revealed: -CPR should not be delayed in the absence of an ambu bag; -CPR can be completed on a soft surface if the rescuers are unable to move the victim from the					
	completing CPR and non-breathing victim supplementary oxyge -While it is optimal to valve mask, or bag va	nnel are responsible for rescue breathing for a even in the absence of en or an ambu bag; use a face shield, one way alve mask, CPR certified ate rescue breathing and				
	on 7/20/21 with the P Practitioner, Vice Pre President of Clinical S	ecutive Vice President				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		MHL036-332	B. WING		07/20	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
EDEEDO!		1089 X RA	Y DRIVE			
FREEDON	Л	GASTONIA	A, NC 28054			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
	Former Client #6 had respiration so CPR shinitiated. CPR is only an absence of a pulse Former Client #5 was Having started CPR vadditional damage to to the ACLS (Advance Support) algorithm for life-threatening emerghas a pulse but an about the patient's airways ir rescue breathing is to -The Executive Vice Formedications are apprefacility and per protocoladministration is appropriate steps are	to be initiate when there is and blood pressure. It is a viable patient. According the according to a viable patient. According the according to a viable patient. According the according to a viable patient of a viable patient the patient the according to a viable patient the patient the according to a viable patient the patient the according to a viable patient the patient the patient the according to a viable patient the patient the according to a viable patient the p				
	diversion of medication by the staff and appropriate to prevent diversion. documentation of obstacles from 12:04am until appropriate to be a medicate from the incident the incident to be a medicate from the incident the incident to be a medicate from the incident the inciden	on. Diversion is anticipated opriate monitoring is in place Acknowledged there was no servation of Former Client #5 oproximately 5:30am on eful review of the incident on lity administration deeming redical incident. All staff ervened and documented of Operations revealed a checked throughout the of 5/3/21 but there was no 30-minute observation of Clinical Services and revealed the facility staff in the issues identified during ontinue to work aggressively				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07/20/	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FREEDOM	Л	1089 X RAY GASTONIA	/ DRIVE ., NC 28054			
(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	(X5) COMPLETE DATE
V 512	to address all challen Review on 7/20/21 of written by the Vice Pr 7/20/21 revealed: "What immediate acti ensure the safety of t Director of Nursing ar Charge Nurse will pro Responsiveness Train Training will include b response protocols, a training/containment. training on emergence and coordination of coattendees will include staff, and all behavior Documentation of train personnel file on-site Monthly Performance be held. These meetic concerns raised by the and fire drills, and rev month with root cause consists of facility lev nursing staff, lead be and clinical coordinate Describe your plans the happens. Vice President of Ope supervision with the F topics will be reviewe addition, the Vice President Vice President Topics will be reviewe addition, the Vice President	the Plan of Protection esident of Operations dated on will the facility take to the consumers in your care? Ind Medication Services and ovide additional Medical thing by Friday 7/23/21. Inehavior associated with pply locations, medical and crisis response Training will also include by codes, role clarification, risis care. Training all nursing staff, all contract al health technicians. Ining will be maintained in at facility. Improvement meetings will rings will be a review of safety the estaff, review of disaster riew of incidents from the the analysis. The committee the staff - Program Director, thavioral health technician, or. To make sure the above Training will hold weekly Program Director and these diduring these meetings. In sident of Operations will monthly Performance	V 512			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE SURVEY COMPLETED (X4) ID PREFIX (X4) ID PREFIX TAG (X2) MULTIPLE CONSTRUCTION A BUILDING: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE SURVEY COMPLETED (X4) ID PREFIX TAGE (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 64 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 on 5/3/21 when he was found unresponsive in his room, blue in color, with labored breathing and low pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLET (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLET (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTION SHOULD BE CROSS-REF	Division of Health Service Regulation					
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MHL036-332 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 28054 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 512 Continued From page 64 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 on 5/3/21 when he was found unresponsive in his room, blue in color, with labored breathing and low pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and						
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TAG Continued From page 64 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and SUMMARY STATEMENT OF DEFICIENCIES GASTONIA, NC 28054						
TAG Continued From page 64 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and SUMMARY STATEMENT OF DEFICIENCIES GASTONIA, NC 28054						
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V 512 Continued From page 64 V 512 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 on 5/3/21 when he was found unresponsive in his room, blue in color, with labored breathing and low pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and	E					
V 512 Continued From page 64 Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 on 5/3/21 when he was found unresponsive in his room, blue in color, with labored breathing and low pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and						
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Staff#6/Registered Nurse is a registered nurse who was caring for Former Client #5 on 5/3/21 when he was found unresponsive in his room, blue in color, with labored breathing and low pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and						
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pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and						
pulse oximetry. Upon assessing Former Client #5 and contacting 911, there was a significant delay in securing necessary equipment and						
#5 and contacting 911, there was a significant delay in securing necessary equipment and						
delay in securing necessary equipment and						
initiation and many cone Chafffe /Degistered						
initiating emergency care. Staff#6/Registered						
Nurse left Former Client #5 with a Licensed						
Practical Nurse and a Behavioral Health						
Technician to retrieve a phone to call 911 rather						
than sending a subordinate for the phone and						
continuing to provide lifesaving measures. She						
failed to secure an AED without prompting from						
the 911 operator and failed to initiate						
cardiopulmonary resuscitation compressions for						
over 7 minutes despite multiple instructions from						
the 911 operator to begin such lifesaving						
measures. This deficiency constitutes a Type A1						
rule violation for serious harm and neglect and						
must be corrected within 23 days. An						
administrative penalty of \$6,000.00 is imposed. If						
the violation is not corrected within 23 days, an						
additional administrative penalty of \$500.00 per						
day will be imposed for each day the facility is out						
of compliance beyond the 23rd day.	I					
V 536 27E .0107 Client Rights - Training on Alt to Rest. V 536						
Int.						
l lite						
10A NCAC 27E .0107 TRAINING ON						
ALTERNATIVES TO RESTRICTIVE	ļ					
INTERVENTIONS	ļ					
(a) Facilities shall implement policies and	ļ					
practices that emphasize the use of alternatives	ļ					
to restrictive interventions.	ļ					
(b) Prior to providing services to people with	J					
disabilities, staff including service providers,						
employees, students or volunteers, shall						

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DIVISION	n Health Service Negu	ilation			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
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		MHL036-332			07/20/	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1089 X RA	Y DRIVE			
FREEDOM	1		A, NC 28054			
			1,110 20004			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
	0 " 15	0.5	V/ 500			
V 536	Continued From page 65		V 536			
	demonstrate compete	ence by successfully				
	completing training in	communication skills and				
	other strategies for cr	reating an environment in				
		of imminent danger of abuse				
		with disabilities or others or				
	property damage is p					
		s shall establish training				
		etencies, monitor for internal				
	•	onstrate they acted on data				
	gathered.	onorate they deted on data				
	•	be competency-based,				
	include measurable le	•				
		written and by observation of				
		pjectives and measurable				
	•	e passing or failing the				
		e passing or railing the				
	course.	training must be completed				
		training must be completed				
		der periodically (minimum				
	annually).					
	(f) Content of the trai					
	=	nploy must be approved by				
	the Division of MH/DI	•				
	Paragraph (g) of this					
	(0)	strate competence in the				
	following core areas:					
	` ,	and understanding of the				
	people being served;					
	` '	and interpreting human				
	behavior;					
		the effect of internal and				
		at may affect people with				
	disabilities;					
		or building positive				
	relationships with per					
	(5) recognizing	cultural, environmental and				
		that may affect people with				
	disabilities;					
		the importance of and				
		n's involvement in making				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
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		MHL036-332	2,0		1 07/20	0/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		1089 X RA	Y DRIVE			
FREEDON	1		A, NC 28054			
			1, 140 20034	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPR		DATE
IAG	REGOLATORI ORT	EGO IDENTIL TING IN ORMATION)	TAG	DEFICIENCY)	WATE	
V 536	Continued From page	e 66	V 536			
	decisions about their	lifo.				
	decisions about their					
	• •	essing individual risk for				
	escalating behavior;					
		tion strategies for defusing				
	and de-escalating pot	tentially dangerous behavior;				
	and					
	(9) positive beh	navioral supports (providing				
	means for people with	h disabilities to choose				
	activities which direct					
	behaviors which are u	·				
	(h) Service providers					
		al and refresher training for				
	at least three years.	ar and refresher training for				
	•	tion shall include:				
	` '					
		ated in the training and the				
	outcomes (pass/fail);					
		vhere they attended; and				
	(C) instructor's					
	` '	n of MH/DD/SAS may				
	=	ocumentation at any time.				
	(i) Instructor Qualification	ations and Training				
	Requirements:					
	(1) Trainers sha	all demonstrate competence				
	by scoring 100% on to	esting in a training program				
	aimed at preventing,	reducing and eliminating the				
	need for restrictive inf	terventions.				
		all demonstrate competence				
	• •	grade on testing in an				
	instructor training pro					
	(3) The training					
		nclude measurable learning				
		le testing (written and by				
	-	ior) on those objectives and				
		to determine passing or				
	failing the course.					
		t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (i)(5	i) of this Rule.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D MING			
		MHL036-332	B. WING		07/20/2021	
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FREEDOM		1089 X RA	Y DRIVE			
FREEDOM		GASTONI	A, NC 28054			
1 1 ()	(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 Contin	ued From page	e 67	V 536			
(5) shall in (A) (B) course (C) perform (D) (6) teachir reducir interve review (7) aimed need for annual (8) instruct (j) Ser docum training (1) (A) outcom (B) (C) (2) request (k) Qu (1) require (2) the course (3) competrain-th (I) Document (II) Document (III) Document (IIII) Document (IIIII) Document (IIII) Document (IIIII) Document (IIIIII) Document (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Acceptable clude but are in understanding methods for methods for methods for methods for methods and documentate. Trainers sharp a training program and eliminate intions at least by the coach. Trainers sharp restrictive in lay. Trainers sharp preventing, or restrictive in lay. Trainers sharp preventing at laying the coach. Trainers sharp preventing for at least the providers entation of initing for at least the procument of the providers entation of initing for at least the procument of the providers of the	instructor training programs not limited to presentation of: ng the adult learner; reaching content of the revaluating trainee ion procedures. all have coached experience ogram aimed at preventing, ting the need for restrictive one time, with positive all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain ial and refresher instructor ree years. entation shall include: nated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: nall meet all preparation ininer. In all teach at least three times eing coached. In all demonstrate oletion of coaching or	V 330			

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		SURVEY PLETED	
			A. DUILDING: _				
		MHL036-332	B. WING		07	//20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE			
FREEDOM	Л		RAY DRIVE NA, NC 28054				
()(1)	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	CORRECTION	(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 536	Continued From page	e 68	V 536				
	failed to ensure all stawere trained in altern interventions prior to 2 of 6 audited staff (\$\frac{9}{6}\$/Registered Nurse; contracted personnel The findings are: Review on 6/17/21 of Hired 4/15/21; -Employed as Behavior-No training in alternating interventions. Review on 6/17/21 of record revealed: -Hired 3/1/21; -Employed as Registing-No training in alternating interventions.	and record review, the facility aff and contracted personnel atives to restrictive providing services affecting staff #5 and Staff) and 1 of 1 audited (Contract Personnel #1). If Staff #5's record revealed: ioral Health Technician; atives to restrictive If Staff #6/Registered Nurse's ered Nurse; atives to restrictive					
	the Program Director -The facility had used	email correspondence from dated 7/9/21 revealed: I six different contracted agencies from 1/1/21 olying a total of 27					
		with the Human Resources empted review of Contract					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LANC	J. JOHNLOHON	DENTI TOATION NOWIDER.	A. BUILDING: _			
		MHL036-332	B. WING		07/2	0/2021
	20//252 02 0//25//55	070557.40	200 017/ 07/	T. T.D. 000.5		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
FREEDON	1	1089 X RA				
		GASTONIA	A, NC 28054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	TREGOLD TOTAL OTTE	is in the second second	TAG	DEFICIENCY)		
			+			
V 536	Continued From page	e 69	V 536			
	Personnel #1's record	d revealed:				
	-There was no record	l available for review:				
		letails regarding Contract				
		sponsibilities, training,				
	experience, and quali					
		ator revealed Contract				
		as a Behavioral Health				
		ere no records maintained				
	on Contract Personnel #1 as she was not an					
	employee of the facility but was contracted					
	personnel provided through a contracted					
	healthcare personnel	•				
	'	3				
	Interview on 6/29/21	with the Vice President of				
	Operations revealed:					
	-No longer using cont	tracted healthcare personnel				
	agencies to provide s					
	-Recognized deficits	with training which resulted				
	in a lack of training fo	r the Behavioral Health				
	Technicians;					
	-Recently implemente	ed a new training system.				
		exit conference conducted				
		rogram Director, Nurse				
		sident of Operations, Vice				
	President of Clinical S					
	-	ecutive Vice President				
	revealed:					
		of Operations revealed				
	training will be comple					
		President revealed it was a				
	•	e trained in alternatives to				
		ns prior to working with				
	clients.					
	-					
		ss referenced into 10A				
		ope (V218) for a Type A1				
		st be corrected within 23				
	days.					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUI 020 222	B. WING		07/0	0/2024
		MHL036-332			07/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE		
FREEDOM	1	1089 X RA GASTONIA	Y DRIVE A, NC 28054			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
V 537	Continued From page	2 70	V 537			
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO		V 537			
	10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OL (a) Seclusion, physic time-out may be emploheen trained and have competence in the proto these procedures. staff authorized to emprocedures are retrain competence at least a (b) Prior to providing of disabilities whose treat includes restrictive int service providers, em volunteers shall comp seclusion, physical re and shall not use these training is completed demonstrated. (c) A pre-requisite for demonstrating competence in the procedure of the providers of the procedure of the providers of the procedure of the providers of the procedure o	CAL RESTRAINT AND JT al restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these med and have demonstrated annually. direct care to people with atment/habilitation plan derventions, staff including ployees, students or olete training in the use of straint and isolation time-out se interventions until the and competence is taking this training is etence by completion of reducing and eliminating te interventions. be competency-based,				
	behavior) on those ob	pjectives and measurable passing or failing the				
	by each service provious annually). (f) Content of the train	loy must be approved by				

Division of Health Service Regulation

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DIVISION	or riealin Service Negu	ialiuri					
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	LETED	
			_				
		MHL036-332	B. WING		07	20/2021	
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	II E, ZIP CODE			
FREEDON	A	1089 X RA	AY DRIVE				
FREEDON	п	GASTONI	A, NC 28054				
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION S		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A		DATE	
				DEFICIENCY)			
V 537	Continued From page	e 71	V 537				
	D	Dodo					
	Paragraph (g) of this						
		ng programs shall include,					
	but are not limited to,	presentation of:					
	(1) refresher int	formation on alternatives to					
	the use of restrictive i	nterventions:					
		on when to intervene					
		ent danger to self and					
	,	ient danger to sen and					
	others);						
		n safety and respect for the					
		Il persons involved (using					
	concepts of least rest	rictive interventions and					
	incremental steps in a	an intervention);					
	(4) strategies fo	or the safe implementation					
	of restrictive intervent						
		mergency safety					
	interventions which in						
		itoring of the physical and					
		ing of the client and the safe					
		ghout the duration of the					
	restrictive intervention	1;					
	(6) prohibited p	rocedures;					
	(7) debriefing s	trategies, including their					
	importance and purpo	ose; and					
		ion methods/procedures.					
	(h) Service providers	•					
		al and refresher training for					
		ar and refresher training for					
	at least three years.	tion aball include:					
	. ,	tion shall include:					
		ated in the training and the					
	outcomes (pass/fail);						
		where they attended; and					
	(C) instructor's	name.					
	(2) The Division	n of MH/DD/SAS may					
		ocumentation at any time.					
	(i) Instructor Qualifica						
	Requirements:	.					
		all demonstrate competence					
		- '					
		esting in a training program					
	∣ aimed at preventing, i	reducing and eliminating the					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED			
MHL036-332		B. WING		07/20/2021				
					1 01/20/2021			
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE				
FREEDOM 1089 X RAY DRIVE								
	•	GASTON	IIA, NC 28054					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()			
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD				
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE			
				,				
V 537	Continued From page	e 72	V 537					
	need for restrictive in	terventions						
		all demonstrate competence						
		•						
		esting in a training program						
	_	eclusion, physical restraint						
	and isolation time-out							
		all demonstrate competence						
		grade on testing in an						
	instructor training pro							
	(4) The training shall be							
	competency-based, include measurable learning							
	objectives, measurable testing (written and by							
	observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the							
	service provider plans	s to employ shall be						
	approved by the Divis	sion of MH/DD/SAS pursuant						
	to Subparagraph (j)(6	i) of this Rule.						
	(6) Acceptable	instructor training programs						
	shall include, but not be limited to, presentation of:							
	(A) understandi	ng the adult learner;						
	(B) methods fo	r teaching content of the						
	course;							
	(C) evaluation	of trainee performance; and						
		tion procedures.						
		all be retrained at least						
	` '	strate competence in the use						
	•	I restraint and isolation						
	time-out, as specified in Paragraph (a) of this							
	Rule.	3 1 ()						
		all be currently trained in						
	CPR.	, 						
		all have coached experience						
		f restrictive interventions at						
	•	a positive review by the						
	coach.	positive review by the						
		all teach a program on the						
	(10) Trainers shall teach a program on the use of restrictive interventions at least once							

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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		07/2	20/2021	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE			
FREEDON	Л		RAY DRIVE IIA, NC 28054				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE	
V 537	Continued From page 73		V 537				
	annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (I) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.						
	failed to ensure all standard failed to ensure all standard failed in seclusionation time-out pricaffecting 2 of 6 audited #6/Registered Nurse	and record review, the facility aff and contracted personnel sion, physical restraint, and or to providing services ed staff (Staff #5 and Staff					
Review on 6/17/21 of Staff #5's record revealed: -Hired 4/15/21;							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.5 / 2.1. 0. 00.1.1.201.011		A. BUILDING:				
	MHL036-332	B. WING		07	/20/2021	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
FREEDOM		RAY DRIVE IIA, NC 28054				
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
-No training in seclusic isolation time-out. Review on 6/17/21 of record revealed: -Hired 3/1/21; -Employed as Register-No training in seclusic isolation time-out. Review on 7/9/21 of ethe Program Director of the Program of th	oral Health Technician; on, physical restraint, and Staff #6/Registered Nurse's ered Nurse; on, physical restraint, and mail correspondence from dated 7/9/21 revealed: six different contracted agencies from 1/1/21 alying a total of 27 with the Human Resources empted review of Contract revealed: available for review; etails regarding Contract sponsibilities, training, fications, the Human attor revealed Contract as a Behavioral Health are no records maintained al #1 as she was not an any but was contracted rough a contracted rough a contracted agency. with the Vice President of	V 537				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL036-332	B. WING		07	//20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
FREEDOM	И		RAY DRIVE NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	-Recently implement Interviews during the on 7/20/21 with the F Practitioner, Vice Pre President of Clinical Management, and Ex revealed: -The Vice President of training will be complement. The Executive Vice policy for all staff to be physical restraint, an working with clients. The deficiency is cross NCAC 27G .3101 Science of the physical restraint.	exit conference conducted Program Director, Nurse esident of Operations, Vice Services and Quality executive Vice President	V 537			

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