	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
			, 20122to. <u> </u>		_	
		MHL043-100	B. WING		09/3	, 0/2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
FREEDON	// CARE SERVICES, LLC		LEVEL ERWII	N ROAD		
TREEDOM	WOARE CERTICES, EEG	ERWIN, NC	28339			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS	,	V 000			
	INITIAL COMMENTS					
	The complaints were	as completed on 9/30/22. substantiated (Intake 00193939). A deficiency				
	This facility is licensed for the following service category: 10A NCAC 27G.5600A Supervised Living for Adults with Mental Illness.  This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 1 deceased client.					
		closed on 6/10/22 but was due to additional complaint				
V 512			V 512			
	27D .0304 Client Rigl	nts - Harm, Abuse, Neglect				
	HARM, ABUSE, NEG (a) Employees s harm, abuse, neglect accordance with G.S. (b) Employees s any sort of abuse or r NCAC 27C .0102 of t (c) Goods or sel purchased from a clie established governing (d) Employees s	. 122C-66.  shall not subject a client to neglect, as defined in 10A his Chapter.  rvices shall not be sold to or ent except through g body policy.  shall use only that degree of				
	force necessary to re aggressive client and governing body policy necessary depends u characteristics of the physical and mental h aggressiveness displa-	pel or secure a violent and which is permitted by y. The degree of force that is				

TITLE

DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
			7. BOILDING.	<del></del>		
					00/3	
		MHL043-100	B. WING		09/3	0/2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
			LEVEL ERWI	N ROAD		
FREEDOM	I CARE SERVICES, LLC	C #4 ERWIN, NC	28339			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(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 512			V 512			
ı	Continued From page	a 1				
		AC 27E of this Chapter. an employee of Paragraphs				
		Rule shall be grounds for				
	dismissal of the empl	S .				
	This Rule is not met a	as evidenced by:				
	Based on record review and interview 1 of 4 staff					
	, , -	deceased client (DC#4).				
	The findings are:					
	Review on 5/26/22 of	DC #4's record revealed:				
	-Admitted: 2/28/21					
	-Deceased: 5/14/22	Dependence, Cigarettes,				
		oaffective Disorder, Bipolar				
	-	ecified essential (primary),				
		stive Heart failure, Chronic				
	Intermittent asthma, u	ry Disease, Unspecified Mild				
	miorimiorii dolimia,	anosmphoatou				
		staff #3's record revealed:				
	- Hired 5/1/19	aprofessional				
		art Saver, First Aid and				
	Cardiopulmonary Res	suscitation (CPR) Automated				
	External Defibrillator	(AED) 12/20/21				
	Interview on 6/1/22 s	taff #3 stated:				
	- DC #4 got up	3:44am and went to the				
		ng out of the bathroom he asked				
	for a breathing treatm	nent athing treatment DC #4 fell on				
	the floor					
		im and his eyes were "cracked				
	opened"					
	- She called 9					
	need CPR"	C #4 "was breathing and did not				

TITLE

DATE

STATE FORM – STATEMENT OF DEFICIENCIES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		MHL043-100	B. WING		09/30/	2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
		3560 BUNN	LEVEL ERWII	N ROAD		
FREEDON	I CARE SERVICES, LLC	: #4				
		ERWIN, NC	28339			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512			V 512			
	Continued From page	2				
	- Called 911, to	old the operator DC #4 was				
	breathing and "not su	-				
	operator said" to her					
		Medical Services (EMS)				
		start an intravenous (IV) port				
	·	ygen mask, a few minutes				
		) pads on him, and another				
	EMS worker went to g	get the AED machine about the do not resuscitate				
		call the guardian to find out				
	about the DNR	call the guardian to find out				
		uardian didn't know about				
	the DNR- EMS stated he was breathing but had a faint pulse					
	A44	0/07/00 with staff #2 was				
		on 9/27/22 with staff #3 was #3 was no longer employed				
		d not have time to answer				
		ons" or talk to the surveyor.				
	Review on 9/12/22 of	the Emergency Call				
		2 regarding DC #4 revealed:				
	staff #3	ll- wrong address given by				
		all the 911 operator asked				
	for the correct addres	=				
		orrect address confirmed				
	•	e was a fill in staff #3 "don't				
	normally work at this	explained going to give				
	instructions to assist I					
		3 to lay DC#4 flat on his				
		thing from his head 2:58				
		e lay him flat on the back				
	3:22 staff #3 stated no	o one there to help her				
		using cell phone to call				
	"boss"	"oithor way we can want				
	him, need you to lay h	- "either way we can work nim flat on his back"				

TITLE

DATE

STATE FORM – STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL043-100	B. WING		09/30/2022	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
EBEEDON	/I CARE SERVICES, LLC		LEVEL ERWII	N ROAD		
FREEDOM	II CARE SERVICES, LLC	ERWIN, NC	28339			
(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 APPROPR DEFICIENCY)	BE COMPL	LETE
V 512			V 512			
	Continued From page	2 3				
	. 3					
	and put him on his ba	r-can you try to move him				
	4:46 staff #3 - "I know	v how he will fight and will				
	knock the fire out of y	ou" r -"that grunting is agonal				
	breathing, and he nee					
	4:57 staff #3 - "I have	been doing this for years, I				
	want make sure he is					
	5:28 staff #3 -cell phone heard going to voicemail 6:12 staff#3 -cell phone going to voice mail 6:25					
	the 911 operator- ask	ed "are you going to call				
		you going to try and help				
	him" 6:27 staff #3 -"I' m go	ing to call someone else"				
	6:34 staff #3 - "I got a	bad back I need help				
	getting him off the floo					
		sation on cell phone "Hey are me help me at the group				
	home, I need you to d					
	"OK someone coming					
	7:27 "they was trying 7:45 staff #3 - "I' m ne	to get him to hospice center"				
		rive and cell phone calling				
	someone else" 9:40 d	call ends				
	Review on 6/6/22 of E 6/14/22 revealed:	Emergency Service chart dated				
		find male pt laying on his				
		by the back sliding door" - cardia" (slower than normal				
	heart rate)	oardia (SiOWEI HIAH HUHHIAI				
	Pulses: Left Rig					
	Carotid: "weak" Not	checked Radial :				
	"weak" Not checked Femoral : Not checke	ed Not checked				
	Dorsalis : Not checke					
		gonal" (breathing when a				
	person is not getting	enough oxygen is gasping cardiac arrest or stroke)				

TITLE

DATE

STATE FORM – STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL043-100	B. WING		C 09/30	0/2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
			LEVEL ERWIN	N ROAD		
FREEDON	I CARE SERVICES, LLC	: #4 ERWIN, NC	28339			
(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 512	revealed: "During an emergence-Call 911 -Determine if CPR/Fin proceed as approprial-Notify the director or -Notify director, legal case manager -Document on incider Interview on 9/28/22 Staff #3 had not work the last 2 months - Staff #3's last termination date was - When she ar was already at the horal company or trainings with staff  Interview on 9/28/22 Staff #3 not unaware of staff #3	the Emergency Policy y staff will:  st Aid is needed and te owner guardian, physicians, or  nt report"  the Licensee stated: - ed at the group home in  t day of work was 7/25/22, 7/30/22 rived at the group home EMS me listened to the 911 call - Was ot following the instructions of the why staff #3 would say DC #4  ot a DNR and there had been no any DNR status at any meetings #3  the Quality Assurance stened to the 911 call from  CPR and First Aid certified	V 512			
	Review on 9/30/22 of 9/30/22 written by the Professional/Licensee	ver discussed with staff #3 the Plan of Protection dated Qualified				

TITLE

DATE

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL043-100	B. WING		C <b>09/30/2022</b>
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	
			LEVEL ERWII		
FREEDON	I CARE SERVICES, LLC		20220		
0/0.15	0.18.88.80.4.87.4	ERWIN, NC			(V5)
(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 APPROPR DEFICIENCY)	BE COMPLETE
V 512			V 512		
	Continued From page	. F			
	Continued From page				
	•	he consumers in your care? follow directions of a 911			
	•	l/emergency officials arrives.			
		erform CPR when directed to			
	do so. The facility will CPR.	retrain staff on			
		o make sure the above			
	happens.				
		ncy situation staff will assess			
	officials."	directions from emergency			
		ad diagnoses to include			
		e, Cigarettes, Uncomplicated			
		der, Bipolar type, Insomnia (primary), Hypertension,			
	Congestive Heart failu	ure, Chronic Obstructive			
	Pulmonary Disease a	ind Unspecified Mild Staff #3 called 911 for			
		#4 fell over after a breathing			
		responsive. Initially staff #3			
		ess for the facility and then uctions given to her. Staff #3			
	was instructed to turn	DC #4 onto his back,			
		plained she had a bad back turn him over. The 911			
		tarn nim over. The 911 taff #3 to start CPR and staff			
	#3 refused as she tho	ought DC #4 was a DNR and			
	wanted to find the par	perwork first. Staff #3 ttempts at reaching other			
		ell phone instead of following			
	the 911 operator's ins	structions to provide			
	lifesaving emergency minutes staff #3 refus	help to DC #4. For over 9 sed to follow the 911			
		s for life saving measures.			
	This deficiency consti				
	violation for serious n	eglect and must be ays. An administrative			
	penalty of \$8,000.00 i	is imposed. If the violation is			
	not corrected within 2				

TITLE

DATE

STATE FORM – STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-100	B. WING		C <b>09/30/2022</b>	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
	3560 BUNNLEVEL ERWIN ROAD					
FREEDON	M CARE SERVICES, LLC	C #4 ERWIN, NC	28339			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 512	. 3	y of \$500.00 per day will be the facility is out of	V 512	DEFICIENCY		

TITLE

DATE

STATE FORM – STATEMENT OF DEFICIENCIES