STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NACOTOR CONTRACTOR CON		MHL043-100	B. WING		C 09/30/2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	and the second s
FREEDO	M CARE SERVICES, LLC	3560 BUNN	LEVEL ERW	IN ROAD	
		ERWIN, NO	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)	RE COMPLETE
V 000					
V 000	INITIAL COMMENTS  A complaint survey w The complaints were	as completed on 9/30/22	V 000	Staff in Quality of Gbosc, neslect + ex The facility was re	platation
	This facility is licensed category: 10A NCAC Living for Adults with	d for the following service 27G.5600A Supervised Mental Illness.		staff in CPR ( with empires of that sta will perform CPR i	aff
	This facility is licensed census of 3. The survaudits of 1 deceased	d for 3 and currently has a sey sample consisted of client.		Breigney officials	7
	This survey originally reopened on 8/27/22 information received.	closed on 6/10/22 but was due to additional complaint		Will retrain state follow directives of	470
V 512			V 512	101000 01100	a tex
	27D .0304 Client Righ	nts - Harm, Abuse, Neglect		emersoney 911 ope The facility Will of	evien
	<ul><li>(a) Employees s</li></ul>	LECT OR EXPLOITATION hall protect clients from		Call individuals per	KIN
	harm, abuse, neglect accordance with G.S. (b) Employees s	122C-66. hall not subject a client to		Centered Plan 1 all staff	
	NCAC 27C .0102 of the	reglect, as defined in 10A nis Chapter. vices shall not be sold to or		Directer will y	polate
	purchased from a clie established governing	nt except through I body policy.		policy to reflect St	to Of
	force necessary to rep aggressive client and governing body policy necessary depends u	. The degree of force that is pon the individual		alco training staff	ructions fon
	physical and mental h aggressiveness displa intervention procedure	client (such as age, size and lealth) and the degree of ayed by the client. Use of les shall be compliance with		DNR if one is pores	Levtle
1	$\bigcirc$ $\bigcirc$	PER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	DATE
TATE FORM	- STATEMENT OF DEFIC	ÈNCIES		152X11	

Received by MHL & C 11/10/22

152X11

Page 1 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL043-100	B. WING		C <b>09/30/2022</b>
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE. ZIP CODE	
			LEVEL ERWIN	NROAD	
FREEDON	I CARE SERVICES, LLC	#4 ERWIN, NC	28339		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 512	(e) Any violation by a (a) through (d) of this dismissal of the employ  This Rule is not met a Based on record revia (#3) neglected 1 of 1 The findings are:  Review on 5/26/22 of -Admitted: 2/28/21 -Deceased: 5/14/22 -Diagnoses: Nicotine Uncomplicated Schiz type, Insomnia Unspet Hypertension, Conge Obstructive Pulmona Intermittent asthma, u  Review on 9/28/22 of - Hired 5/1/19 - Job title-Para - Training: Hec Cardiopulmonary Res External Defibrillator  Interview on 6/1/22 s - DC #4 got u bathroom, after comi for a breathing treatm - After the bre the floor - She shook h opened" - She called 9	C 27E of this Chapter. In employee of Paragraphs Rule shall be grounds for oyee.  It is evidenced by: It i	V 512	Monitoring well be carducted on site management and Quality ASSUrance manager Merchy. I fund told in nor compliance well are respected immed and reviewed at monthly howse he monthly meeting are conducted by approve manager.	Anything Use laters
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MONTH OF THE STATE		MHL043-100	B. WING		C 09/30/2022	
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FREEDO	W CARE SERVICES, LLC	3560 BUNN	LEVEL ERWII	N ROAD		
		ERWIN, NO	28339			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
V 512			V 512			
	0	_				
Continued From page 2  Called 911, told the operator DC #4 was breathing and "not sure what else the 911 operator said" to her Emergency Medical Services (EMS) arrived, they tried to start an intravenous (IV) port and put him on an oxygen mask, a few minutes later they put the AED pads on him, and another EMS worker went to get the AED machine  EMS asked about the do not resuscitate (DNR) then asked to call the guardian to find out about the DNR — The on-call guardian didn't know about the DNR - EMS stated he was breathing but had a faint pulse  Attempted interview on 9/27/22 with staff #3 was unsuccessful as staff #3 was no longer employed by this facility and "did not have time to answer any additional questions" or talk to the surveyor.  Review on 9/12/22 of the Emergency Call recording from 6/14/22 regarding DC #4 revealed: 9 seconds into the call-wrong address given by staff #3  40 seconds into the call the 911 operator asked for the correct address of the call wrong address onfirmed 1.44 staff reported she was a fill in staff #3 "don't normally work at this home!"  2.05 the 911 operator explained going to give instructions to assist DC #4  2.20 instructed staff #3 to lay DC#4 flat on his back and remove anything from his head 2:56 asked staff #3 did she lay him flat on the back 3.22 staff #3 staded no one there to help her 3.48 staff #3 reported using cell phone to call "boss"						
ga ani paga na	4:00 the 911 operato	r- "either way we can work				
LABORATOR	him, need you to lay	him flat on his back"  DER/SUPPLIER REPRESENTATIVE'S SK	SNATURE	TITLE	DATE	
STATE FORM – STATEMENT OF DEFICIENCIES 152X11						

152X11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (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		RESS, CITY, STA	TE ZID CODE		$\dashv$
THE OT THE	WIDER OR OUT FEEL		LEVEL ERWIN			
FREEDON	I CARE SERVICES, LLC	C #4		TROAD		
(XA) ID	CLIMMADY CT	ERWIN, NC				$\dashv$
(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 COMPLET	E
						_
V 512			V 512			
	Continued From page	e 3				
	4:26 the 911 operator	r-can you try to move him				
	and put him on his ba	ack				
		v how he will fight and will				
	knock the fire out of y					
	breathing, and he nee	r -"that grunting is agonal				
		been doing this for years, I				
	want make sure he is					
		one heard going to voicemail				
		ne going to voice mail 6:25				
		ked "are you going to call you going to try and help				
	him"	you going to try and neip				
	6:27 staff #3 -"I' m go	oing to call someone else"				
		a bad back I need help				
	getting him off the flo					
		sation on cell phone "Hey are me help me at the group				
	home, I need you to					
	"OK someone coming					
	7:27 "they was trying	to get him to hospice center"				
	7:45 staff #3 - "I' m no					
	someone else" 9:40	rrive and cell phone calling				
	331100110 0100 0.40	odii Orido				
-	Review on 6/6/22 of I 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)	~!~!				
	Pulses: Left Rig Carotid: "weak" No	ght t checked Radial :				
	"weak" Not checked	CHECKEU Naulai .				
	Femoral : Not checke	ed Not checked				
	Dorsalis : Not checke					
		agonal" (breathing when a				
	person is not getting	enough oxygen is gasping				
	for air, usually due to	cardiac arrest or stroke)				
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	DATE	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
entra mengeripa anta menjelah di alah kelebah kelebah kenglah dalah di	n de farmen greum en de grande ar mora una fais plache, mo une en depuny de grand a la paragona anno acceptant	MHL043-100	B. WING	_	1	C 30/2022	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	E, ZIP CODE			
FREEDOM CARE SERVICES, LLC #4							
TALLOON	NOANE 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 512	Continued From page	e 4	V 512				
	Respiratory exam: "C	hest, Equal Rise/Fall"					
	Review on 9/28/22 of	the Emergency Policy					
	revealed: "During an emergeno	cy staff will:					
	-Call 911 -Determine if CPR/Fi						
	proceed as appropria	ite					
	-Notify the director or -Notify director, legal	owner guardian, physicians, or					
	case manager -Document on incide						
	Staff #3 had not work the last 2 months  - Staff #3's last termination date was - When she at was already at the ho - She had not unaware of staff #3 n 911 operator - Did not know was a DNR - DC #4 was n	rrived at the group home EMS					
	or trainings with staff						
	Manager stated:	istened to the 911 call from					
	- Staff #3 was	CPR and First Aid certified not a DNR ever discussed with staff #3					
	9/30/22 written by the Professional/License	f the Plan of Protection dated e Qualified e (QP) revealed: ction will the facility take to					
LABORATO	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	DA	TE	

DATE

MMLO43-100  MHLO43-100  BINNING OF PROVIDER OR SUPPLIER  STREED ADDRESS, CITY, STATE, ZIP CODE  3569 DUNING LEVEL ERWIN ROAD  ERWIN, NC 23399  PROVIDER'S PLAN OF CORRECTION  PREFIX THA  CONSUMMANY STATEMENT OF DEFICIENCIES (PACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCE TO THE APPROPRIATE DEFICIENCY THA  CONSUMMANY STATEMENT OF DEFICIENCIES  RESULATORY OR LISC DESTITATING INFORMATION)  V 512  V 512  Continued From page 5  ensure the safety of the consumers in your care? The facility /staff will follow directions of a 911 operator until medicalemergency officials arrives. The facility/staff will perform CPR when directed to do so. The facility will retrain staff on CPR. Describe your plans to make sure the above happens. If staff is in a emergency situation staff will assess the scene and follow directions from emergency officials."  Deceased client #4 had diagnoses to include Nicotine Dependence, Cigarettes, Uncomplicated Schizocaffective Disorder, Bipolar type, Insomnia Unspecified essential (primary), Hypertension, Congestive Heart failure, Chronic Obstructive Pulmonary Disease and Unspecified Mill Intermittent Asthma. Staff #3 called 911 for assistance when DC 44 fell over after a breathing treatment and vasu unresponsive, Initially staff #3 would not follow instructions given to her Staff #3 was instructed to turn DC #4 onto his back, however staff #5 complained she head a back back herself and could not turn him over. The 911 Operator instructed staff #3 to start CPR and staff #3 refused as she thought DC #4 was a DNR and wanted to find the paperwork first. Staff #3 proceeded to make attempts at reaching often includes staff #3 refused to 1000 with 91 wholl and the paperwork first. Staff #3 proceeded to make attempts at reaching often includes staff #3 refused of follow the 91 wholl and the paperwork first. Staff #3 proceeded to make attempts at reaching often includes staff #3 refused as the character.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE. ZIP CODE  STREED ON CARE SERVICES, LLC #4  PREDIOM CARE SERVICES,							
PREEDOM CARE SERVICES, LLC 44  PRETIX SUBMENT STATEMENT OF PERIODENIES PROCESSED OF YALL REGULATORY OR LIST DEPTITION OF THE PROPERTY OF THE P			MHL043-100	B. WNG			
SAMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLANOF CORRECTION   CACH CORRECTIVE ACTION SHOULD BE CACH CACH CACH CACH CACH CACH CACH CAC	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
SIMMARY STATEMENT OF DESIDIENCIES   SIMMARY STATEMENT OF DESIDIENCIES   PROVIDER'S ITAN OF CORRECTION ACTION SHOULD BE (EACH DESIDIENCY MUST BE PRECEDED BY FULL TAG)   PROVIDER'S ITAN OF CORRECTION ACTION HIGHURD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   TO STATE APPROPRIATE   DEFICIENCY      V 512	FREEDON	I CARE SERVICES. LLC		LEVEL ERWIN	NROAD		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  CROSS-REFERENCED THE APPROPRIATE  CROSS-REFERENCED  CROSS-REFERENCED  CROSS-REFERENCED  CROSS-REFERENCED  CR							
Continued From page 5 ensure the safety of the consumers in your care? The facility /staff will follow directions of a 911 operator until medical/emergency officials arrives. The facility/staff will perform CPR when directed to do so. The facility will retrain staff on CPR. Describe your plans to make sure the above happens. If staff is in a emergency situation staff will assess the scene and follow directions from emergency officials."  Decassed client #4 had diagnoses to include Nicotine Dependence, Cigarettes, Uncomplicated Schizoaffective Disorder, Bipolar type, Insomnia Unspecified essential (primary), Hypertension, Congestive Heart failure, Chronic Obstructive Pulmonary Disease and Unspecified Milid Intermittent Asthma. Staff #3 called 911 for assistance when DC #4 fell over after a breathing treatment and was unresponsive. Initially staff #3 gave the wrong address for the facility and then would not follow instructions given to her. Staff #3 was instructed to turn DC #4 onto his back, however staff #3 complained she had a bad back herself and could not turn him over. The 911 Operator instructed staff #3 to start CPR and staff #3 refused as she thought DC #4 was a DNR and wanted to find the paperwork first. Staff #3 proceeded to make attempts at reaching other facility staff via her cell phone instead of following the 911 operator's instructions to provide lifesaving emergency help to DC #4. For over 9 minutes staff #3 refused to follow the 911 operator's instructions for life saving measures. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
ensure the safety of the consumers in your care? The facility /staff will follow directions of a 911 operator until medical/emergency officials arrives. The facility/staff will perform CPR when directed to do so. The facility will retrain staff on CPR. Describe your plans to make sure the above happens. If staff is in a emergency situation staff will assess the scene and follow directions from emergency officials."  Deceased client #4 had diagnoses to include Nicotine Dependence, Cigarettes, Uncomplicated Schizoaffective Disorder, Bipolar type, Insomnia Unspecified essential (primary), Hypertension, Congestive Heart failure, Chronic Obstructive Pulmonary Disease and Unspecified Mild Intermitent Asthma, Staff #3 called 911 for assistance when DC #4 fell over after a breathing treatment and was unresponsive. Initially staff #3 gave the wrong address for the facility and then would not follow instructions given to her. Staff #3 was instructed to turn DC #4 onto his back, however staff #3 complained she had a bad back herself and could not turn him over. The 911 Operator instructed staff #3 to start CPR and staff #3 refused as she thought DC #4 was a DNR and wanted to find the paperwork first. Staff #3 proceeded to make attempts at reaching other facility staff via her cell phone instead of following the 911 operator's instructions to provide lifesaving emergency help to DC #4. For over 9 minutes staff #3 refused to follow the 911 operator's instructions for life saving measures. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative	V 512			V 512			
penalty of \$8,000.00 is imposed. If the violation is not corrected within 23 days, an additional  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  DATE	LABORATOR	ensure the safety of the facility /staff will for operator until medica. The facility/staff will place so. The facility will CPR.  Describe your plans thappens.  If staff is in a emerge the scene and follow officials."  Deceased client #4 heart Nicotine Dependence Schizoaffective Disor Unspecified essential Congestive Heart fail Pulmonary Disease and Intermittent Asthma. assistance when DC treatment and was ungave the wrong addrewould not follow instremation was instructed to turn however staff #3 comberself and could not Operator instructed shall wanted to find the paproceeded to make a facility staff via her center operator's instruction. This deficiency constitution for serious recorrected within 23 depenalty of \$8,000.00 not corrected within 23 depenants of the same safety of \$8,000.00 not corrected within 23 depenants of the safety of \$8,000.00 not corrected within 23 depenants of the safety of \$8,000.00 not corrected within 23 depends of the safety of \$8,000.00 not corrected within 23 depends of the safety of \$8,000.00 not corrected within 23 depends of the safety of \$8,000.00 not corrected within 23 depends of the safety of \$8,000.00 not corrected within 24 depends of the safety of t	he consumers in your care? follow directions of a 911 l/emergency officials arrives. erform CPR when directed to retrain staff on to make sure the above and diagnoses to include to Cigarettes, Uncomplicated der, Bipolar type, Insomnia I (primary), Hypertension, ture, Chronic Obstructive and Unspecified Mild Staff #3 called 911 for #4 fell over after a breathing thresponsive. Initially staff #3 tess for the facility and then tuctions given to her. Staff #3 to DC #4 onto his back, turn him over. The 911 taff #3 to start CPR and staff tought DC #4 was a DNR and perwork first. Staff #3 tempts at reaching other tell phone instead of following structions to provide the hold by the political staff to both the provide of the provide of the provide of the provide of the politic saving measures. Situtes a Type A1 rule the place of the violation is to provide of the politic saving measures. Situtes a Type A1 rule the place of the violation is to provide of the place of the pla	CNATURE		DAT	

I AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL043-100	B. WING		C 09/30/2022	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FREEDON	I CARE SERVICES, LLC	3560 BUNN	ILEVEL ERWII	NROAD		
		ERWIN, NO			entritorio (militario de la militario de la disposició de la constante de la constante de la constante de la c	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	Continued From page	e 6	V 512			
	,	y of \$500.00 per day will be y the facility is out of				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE DATE						
STATE FORM – STATEMENT OF DEFICIENCIES 152X11						