STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		7. Bolesino.		R		
		MHL043-102	B. WING		1	0/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	11C#6	.OW FORD S N, NC 28326			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTE DATE
V 000	INITIAL COMMENT	rs	V 000			
		w up survey was completed a deficiency was cited.				
		sed for the following service C 27G .5600A Supervised th Mental Illness.				
		sed for 6 and currently has a urvey sample consisted of clients.				
V 366	27G .0603 Incident	Response Requirements	V 366			
	implement written presponse to level I, shall require the pro (1) attending of individuals involv (2) determini (3) developin measures accordin timeframes not to e (4) developin to prevent similar ir specified timeframe (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintainii	DIREMENTS FOR DISTRIBUTION DIST				
	Subparagraphs (a)	(1) through (a)(6) of this Rule. the requirements set forth in				

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

(X6) DATE TITLE

MHL043-102 STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NO. 28326 CAMERON, NO. 283	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED	
MHL043-102 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			A. BUILDING.		_	,	
CAMPID SUMMARY STATEMENT OF DEFICIENCES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFY INFORMAT	MHL043-102		B. WING				
CAMERON, NC 28326 (XA) D PROVIDER'S PLAN OF CORRECTION	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (EACH DEFICIENCY) V 366			34 SHALI	OW FORD S	STREET		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 1 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to	FREEDO	OM CARE SERVICES,	LLC #6 CAMERO	N, NC 28326	3		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 1 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to	(X4) ID	SUMMARY STA		1		ON	(X5)
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and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is	V 300	Paragraph (a) of this shall address incider regulations in 42 Cl (c) In addition to the Paragraph (a) of this providers, excluding develop and implementation their response to a while the provider is or while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is the policies shall response to a while the provider is a while the pro	is Rule, ICF/MR providers ents as required by the federal FR Part 483 Subpart I. The requirements set forth in its Rule, Category A and B g ICF/MR providers, shall ment written policies governing level III incident that occurs is delivering a billable service is on the provider's premises. The equire the provider to respond the client record the client record; in photocopy; if the copy's completeness; and ing the copy to an internal g a meeting of the incident. The inshall consist of individuals wed in the incident and who all for the client's direct care or onal oversight of the client's erof the incident. The internal complete all of the activities as the copy of the client record to be and causes of the incident endations for minimizing the red incidents; ther information needed; then preliminary findings of fact days of the incident. The sof fact shall be sent to the	V 300			

6899

Division of Health Service Regulation STATE FORM

ABNM11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION (X3) DATE S COMPL		E SURVEY PLETED		
MHL043-102			B. WING 0			R 4/30/2024	
	PROVIDER OR SUPPLIER OM CARE SERVICES,	11 C #6 34 SHAL	DDRESS, CITY, ST LOW FORD ST DN, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 366	(D) issue a fir owner within three final report shall be catchment area the LME where the clie final written report sidentified by the intrinclude all public do incident, and shall minimizing the occuall documents need available within three months to sul (3) immediat (A) the LME rarea where the ser Rule .0604; (B) the LME different; (C) the provider maintaining and treatment plan, if diprovider; (D) the Depar (E) the client applicable; and	nal written report signed by the months of the incident. The sent to the LME in whose exprovider is located and to the nt resides, if different. The shall address the issues ernal review team, shall ocuments pertinent to the make recommendations for urrence of future incidents. If ded for the report are not expended to the incident, the provider an extension of up to bomit the final report; and ely notifying the following: responsible for the catchment vices are provided pursuant to where the client resides, if the der agency with responsibility applications are provided pursuant to the firm the reporting the form the reporting					
	failed to implement	view and interview the facility policies for g to level one incidents as					

Division of Health Service Regulation

STATE FORM 6899 ABNM11 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED	
		A. BOILDING.			R	
		MHL043-102	B. WING			30/2024
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADI			STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	1 1 C: #6	LOW FORD S ON, NC 28320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From pa	ige 3	V 366			
	-43 year old maleAdmitted on 4/30/2 -Diagnosis of Schiz Review on 4/30/24 Administration Recrevealed the followi-Clozapine 25 millig Psychosis on 3/9/2 3/26/24 (PM)Clozapine 50 mg to 3/9/24 (AM), 3/12/2 -Lithium Carbonate Mood on 3/9/24 (AM)Metformin HCL 50 and supper on 3/26 -Metoprolol SCC El 3/25/24 an 3/26/24Polyethylene Glycolom 3/9/24 and 3/12/2 -Senna 8.6 mg eve (Stool) -Vitamin D3 1000 Il 3/26/24, 3/28/24. (SC) Client #6 was hosp interview. Client #6 discharge date of 4 Interview on 4/30/24 -Professional stated -There were no leve #6's medication refinal/25/26, 3/26/24.	of client #6's Medication ord from 2/1/24 - 4/30/24 ing medication refusals: gram (mg) twice daily for 4 (AM), 3/12/24 (AM) and wice daily for Psychosis on 4 (AM) and 3/26/24 (PM). ER 300 mg twice daily for M), 3/12/24 (AM) and 3/26/24 O mg twice daily with lunch 3/24. (High Blood Pressure) R 50 mg daily at 6pm on (High Blood Pressure) on 3/50 Powder every morning (24. (Stool) ry morning on 3/9/24, 3/12/24. U tab (25 mcg) daily at 6pm on Supplement) italized and not available for also had an anticipated (3/30/24. 4 the Licensee/Qualified it el I incident reports for client usals on 3/9/24, 3/12/24,				
		r incident reports on 3/9/24 behaviors but it had not refusals.				

Division of Health Service Regulation

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		MHL043-102	B. WING			R 30/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FREEDO	M CARE SERVICES,	11(:#6	LOW FORD S ON, NC 28326				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 366	Continued From pa	ge 4	V 366				
		stitutes a re-cited deficiency					

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