	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL043-102	B. WING		05/21/	2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	11C#6	LOW FORD S N, NC 28326			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual survey w 2025. Deficiencies	vas completed on May 21, were cited.				
	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 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.					
V 513	27E .0101 Client Ri Alternative	ights - Least Restrictive	V 513			
	Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		MHL043-102	B. WING		05/	21/2025
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
FREEDO	OM CARE SERVICES,	I I C #6	LLOW FORD S [*] ON, NC 28326	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 513	Continued From pa	ge 1	V 513			
	interviews the facilir restrictive and mos methods were used findings are: Review on 5/21/25 -Admitted on 6/4/18 -Diagnosis of Parar-No documentation rights restriction or as required every 7 Review on 5/21/25 -Admitted on 6/21/19 -Diagnoses of Schill Unspecified Disrup Conduct Disorder, disorderNo documentation	views, observation and ty failed to ensure the least t appropriate settings and d affecting 3 of 5 clients. The of client #1's record revealed 3. noid Schizophrenia. of detailed reason for the restriction reviewed by a QP days. of client #3's record revealed 19. zophrenia undifferentiated and tive, Impulse Control and Insomnia due to other mental of detailed reason for the restriction reviewed by a QP	d			
	-Admitted on 5/28/2 -Diagnosis of Schiz -No documentation	ophrenia. of detailed reason for the restriction reviewed by a QP				
	a tour of the facility -A black wire wrapp door handles.	0/25 at approximately 6:30pm revealed: ped around the refrigerator's ry containing snacks, drinks,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				D. WING			
		MHL043-1	102	B. WING		05/2	1/2025
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
FREEDO	M CARE SERVICES,	LLC #6		.OW FORD S N, NC 28326			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 513	Continued From pa	ge 2		V 513			
	Interview on 5/19/29. The pantry and refriended not have act and refrigerator. -He "just ask somes" -He could only get a otherwise he drank. Interview on 5/19/29. -The refrigerator and no one can steal form the does not knowher eceived snack. Interview on 5/20/29. -The refrigerator and the received snack. Interview on 5/20/29. -The refrigerator and the refr	igerator were keepers to the key times they will go a drink of choice water. 5 client #3 state of pantry were keepers at snack time 5 staff #1 state of pan	ept locked. If for the pantry give it to you." e at dinner ed: kept locked. kept locked so is kept. d: kept locked.				
	Interview on 5/21/2: -The refrigerator an -He was unsure wh were lockedThe client asked si wanted. Interview on 5/21/2: (QP) stated: -There was an indiv	d pantry were key the refrigerated taff to get whaten the Qualified	ept locked. or and pantry ever they Professional				
	-Client # 4 took spid a month ago. -There is a monthly a need for the restr -The restriction is n	ces and tried to meeting to see iction on rights.	smoke it about				

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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:					
		MHL043-102	B. WING		05/2	1/2025		
NAME OF I	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 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 513	Interview on 5/19/2 -The clients had ac -The facility reviews the clinical meeting -The facility would of note if there was ar -She did not have a 3 monthsThe restriction was documented in the	5 the Licensee/QP stated: cess to the key. s restrictions monthly during s. do an incident report or service n issues. any incident reports for the last s not evaluated every 7 days or	V 513					
	Int. 10A NCAC 27E .01 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall in practices that emptote to restrictive interversion (b) Prior to providing disabilities, staff incompleting training other strategies for which the likelihood or injury to a person property damage is (c) Provider agency based on state components and degathered. (d) The training shall include measurable measurable testing behavior) on those	07 TRAINING ON O RESTRICTIVE Implement policies and nasize the use of alternatives entions. Ing services to people with cluding service providers, ts or volunteers, shall etence by successfully in communication skills and creating an environment in d of imminent danger of abuse in with disabilities or others or						

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MHL043-102 NAME OF PROVIDER OR SUPPLIER FREEDOM CARE SERVICES, LLC #6 STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 34 SHALLOW FORD STREET CAMERON, NC 28326 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 4 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.				A. BUILDING:				
FREEDOM CARE SERVICES, LLC #6 CAMERON, NC 28326 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 4 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.		MHL043-102		B. WING		05/2	21/2025	
CAMERON, NC 28326 CAME	NAME OF PROVIDER OR SUP	LIER STREET A	VIDER OR SUPPLIER	DDRESS, CITY, S	TATE, ZIP CODE			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 4 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	EDEEDOM CADE CEDVI	34 SHAI		LOW FORD S	TREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 4 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	FREEDOM CARE SERVI	CAMER	CARE SERVICES,	N, NC 28326				
(e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	PREFIX (EACH DEFIC	ENCY MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE	
(e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	V 536 Continued Fro	n page 4	ontinued From pa	V 536				
following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the	(e) Formal refeat by each service annually). (f) Content of provider wisher the Division of Paragraph (g) (g) Staff shall following core (1) know people being s (2) recomplete being s (2) recomplete being s (3) recomplete being s (4) strate relationships w (5) recomplete being s (5) recomplete being s (6) recomplete being s (7) skills escalating in the decisions about (7) skills escalating before (8) compand de-escalating before (8) compand de-escalating before (9) positions and (9) positions which is provided behaviors which is provided the service prodocumentation at least three services and the service prodocumentation at least three services and services and the services prodocumentation at least three services and services and services and services are services and services and services are services and services and services and services and services are services and services and services and services are services and services and services are services and services and services and services are services are services and services are services are services and services are services and services are services are services are services and services are services are services and serv	resher training must be completed by provider periodically (minimum) the training that the service is to employ must be approved by MH/DD/SAS pursuant to of this Rule. Idemonstrate competence in the areas: Idedge and understanding of the erved; Inizing and interpreting human in the priority and interpreting human int	Promal refresh (each service pronually). Content of the covider wishes to be Division of MH aragraph (g) of the covider wishes to be Division of MH aragraph (g) of the covider wishes to be provided by the covider wishes to be completed by the covider wishes th					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-102	B. WING		05/2	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FDFFDA	M OADE OEDVIOEO	34 SHALL	OW FORD S	STREET		
FREEDO	M CARE SERVICES,	CAMEROI	N, NC 28326	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 5	V 536			
	(B) when and (C) instructor (2) The Division review/request this (i) Instructor Qualiff Requirements: (1) Trainers is by scoring 100% or aimed at preventing need for restrictive (2) Trainers is by scoring a passing instructor training period (3) The training competency-based objectives, measurable method failing the course. (4) The contest of approved by the Divito Subparagraph (i) (5) Acceptable shall include but are (A) understand (B) methods course; (C) methods performance; and (D) document (6) Trainers is teaching a training reducing and eliming interventions at least review by the coach (7) Trainers is aimed at preventing and at	I where they attended; and 's name; ion of MH/DD/SAS may documentation at any time. ications and Training shall demonstrate competence in testing in a training program greducing and eliminating the interventions. It is also to determine passing or any				

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STATE FORM 6899 MRKY11 If continuation sheet 6 of 8

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL043-102	B. WING		05/2	21/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FREEDOM CARE SERVICES, LLC #6 CAMERO			OW FORD S				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORREST TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 536	instructor training a (j) Service provided documentation of ir training for at least (1) Docur (A) who particulate outcomes (pass/fai) (B) when and (C) instructor (2) The Divisic request and review (k) Qualifications of (1) Coaches requirements as a to (2) Coaches the course which is (3) Coaches competence by contrain-the-trainer instructor	shall complete a refresher t least every two years. It is shall maintain nitial and refresher instructor three years. It mentation shall include: sipated in the training and the sipated in the sip	V 536				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure annual training in alternatives to restrictive interventions for one of three audited staff (Licensee/Qualified Professional (QP)). The findings are: Review on 5/20/25 of the L/QP's personnel record						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		MHL043-102	B. WING		05/2	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FREEDOM CARE SERVICES 11 C #6		_OW FORD S N, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 536	revealed: -Hire date: -No documentation alternatives to restr Interview on 5/20/2 -The facility did not interventionsHer alternatives to expired.	of a current annual training in rictive interventions. 5 the L/QP stated: use physical restrictive restrictive interventions had d to for annual alternatives to	V 536			

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