DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				SURVEY PLETED
		34G257	B. WING			07/	/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE	RESIDENTIAL				8 HILLSIDE STREET		
				С	CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 032	 Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: 		E	032			
	(3) Primary and alterr communicating with ti(i) [Facility] staff.(ii) Federal, State, trib emergency managem	he following: pal, regional, and local					
	*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is:						
		evelop an alternate means th staff, regional and local an emergency.					
	preparedness (EP) pl	he facility's emergency an (revised 5/21/18) did not on regarding alternate tion.					
	were unaware of any	n 7/2/18, staff stated they alternate communication e event of an emergency personal cellphones.					

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

TITLE

(X6) DATE

PRINTED: 07/06/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	<u>O. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	PLETED
		34G257	B. WING		07	//03/2018
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	DE	
MIDLAKE	RESIDENTIAL			HILLSIDE STREET ARKTON, NC 28433		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 032	Continued From page	e 1	E 032			
W 240	intellectual disabilities an in regards to an al communication "noth	ing has been put in place." RAM PLAN	W 240			
		m plan must describe to support the individual e.				
	Based on observatio interview the facility fa information in 1 of 3 a program plan (IPP) s behavioral/environme	ailed to include specific audit client's (#6) individual pecific to				
	did not include specif	g mealtime to address her				
	kitchen ledge eating l 1:1 with her assisting a spoon and drinking built up sectioned pla utensils. Her food tex	of lunch on 7/2/18 at as seated in a chair at the unch. Direct care staff was her scooping her food using from a cup. She utilized a te and regular cups and xture was pureed. The other in the dining room table with				

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	-	D HUMAN SERVICES				FORM	: 07/06/2018 APPROVED
STATEMENT C	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	
		34G257	B. WING			07/0	03/2018
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MIDLAKE	RESIDENTIAL			HILLSIDE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 240	also seated at the kito 1:1 direct care staff as mealtime. During both were seated at the dir care staff. Interview on 7/2/18 w client #6 was seated in other clients because to reach for the other interview revealed he pureed and consuming other than her prescrit to her and can be dist Review on 7/3/18 of con- revealed she is prescrited with a pureed diet text IPP revealed client #60 plate and that she "ea- eats independently." Review on 7/3/18 of con- addresses severe dist aggression, property for accidents and PICA. and the BSP revealed separating client #60 in room and kitchen dur inappropriate behavior Interview on 7/3/18 w disabilities profession no information in the for- regarding separating the facility during mea- time to the table to ta	at breakfast client #6 was chen ledge in a chair with ssisting her during in meals, the other 5 clients hing room table with direct ith direct care staff revealed in the kitchen away from the she will sometimes attempt client's food. Further r food texture is to be ing another food texture, bed diet, poses a safety risk ruptive during mealtime. client #6's IPP dated 6/28/18 cribed a heart healthy diet ture. Further review of the buses a built up sectioned ats family style dining and client #6's BSP dated 8/4/17 ruptive behavior, destruction, toileting Further review of the IPP a no information regarding in another area of the dining ing mealtimes due to her ors. ith the qualified intellectual al (QIDP) revealed there is IPP or the BSP for client #6 her from the other clients in altimes. Further interview seated at the kitchen ledge	W 240				

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If continuation sheet Page 3 of 17

		MEDICAID SERVICES				IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
		34G257	B. WING		0	7/03/2018	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODI	E		
MIDLAKE	RESIDENTIAL			HILLSIDE STREET ARKTON, NC 28433			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
W 240	Continued From page reasons due to her ne	e 3 eed for increased staffing	W 240				
W 242	and safety concerns a INDIVIDUAL PROGR CFR(s): 483.440(c)(6	AM PLAN	W 242				
	The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.						
	Based on observatio interview the interdisc ensure objective train	not met as evidenced by: ns, record review and ciplinary team failed to ning to meet identified needs are implemented for 1 of 3 e finding is:					
	Client #4's interdiscip establish training in th address his personal	ne area of toileting to					
	11:55am, the top of c could be seen at the walked through the liv Direct care staff stopp	n the facility on 7/2/18 at lient #4's disposable brief top of his shorts while he ving room area of the facility. bed him and readjusted his overed the top of his shorts.					
	client #4 is incontiner	ith direct care staff revealed t of bowel and bladder and efs throughout the day and					

	-	ID HUMAN SERVICES				FORM	: 07/06/2018 APPROVED
							. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	
		34G257	B. WING			07/0	3/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
MIDLAKE	RESIDENTIAL		_	B HILLSIDE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ⁻ FICIENCY)		(X5) COMPLETION DATE
W 242	Continued From page toileting schedule.	: 4	W 242				
	client #4 was admitted Review of his individu dated 6/22/18 reveale and bladder and wear throughout the day an	nd night. Further interview ot any objective training #4 to make him more					
W 262	disabilities profession is incontinent of bowe disposable briefs and for toileting accidents. no consideration by th establish any objectiv toileting for client #4. revealed he has not b	is checked every 2 hours Further interview there was ne interdisciplinary team to e training in the area of Additional interview been evaluated by his e if there is any medical trained in the area of RING & CHANGE	W 262				
	monitor individual pro inappropriate behavio	d review, approve, and grams designed to manage or and other programs that, committee, involve risks to rights.					
	Based on observation interview, the facility f						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 34G257 B. WING 07/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **68 HILLSIDE STREET** MIDLAKE RESIDENTIAL CLARKTON, NC 28433 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 262 Continued From page 5 W 262 audit clients (#4, #6) were reviewed and monitored by the human rights committee (HRC). The findings are: Client #4's behavioral restrictions and psychotropic medications were not reviewed by the HRC. During observations in the facility on 7/2/18 at 5:06pm client #4 was sitting outside on the back porch with the residential manager. He was observed attempting to hit himself several times, he also attempted to hit himself in the eye. Staff put bilateral mittens on his hands that tied on the outside of each mitten. Client #4 could not remove the mittens. Interview on 7/2/18 with the Residential manager (RM) revealed the mittens are part of behavioral guidelines established by the Psychologist to address client #4's severe attempts at self-injurious behavior. Further interview revealed the mittens cannot remain on his hands more than 1 hour 15 minutes without a break for 15 minutes. She stated often after about 10 minutes he is calm enough to remove the mittens. She states they document this on his behavioral data sheet. Review on 7/2/18 of client #4's record revealed he was admitted to the facility on 5/21/18. Review of his individual program plan (IPP) revealed he has target behaviors of self-injurious behavior which was addressed by behavior guidelines. Further review of the behavior guidelines dated 5/24/18 revealed this included the use of a non-contingent device using mittens that were to applied when he attempts to hit himself or tries to poke himself in the eye. The mittens are to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/06/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 07/06/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	
		34G257	B. WING		07/	03/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE	RESIDENTIAL			68 HILLSIDE STREET CLARKTON, NC 28433		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 262	applied by staff and ti be removed by client remain on his hands in minutes without a breat this non-contingent do the behavioral data sli Review on 7/3/18 of t 6/5/18 for client #4 res Seroquel 50 mg. seven his inappropriate beha at night for sleep. Review of the Human minutes revealed the restriction and the use Trazedone for client # by HRC. The last met before client #4 was at Interview on 7/3/18 w disabilities profession not contacted the HR correspondence to has reviewed since client 2. The HRC did not re- involving psychotropio utilized for sleep or te her inappropriate behavior 12:08pm, client #6 was kitchen ledge eating I 1:1 with her assisting a spoon and drinking built up sectioned pla- utensils. Her food tex-	 e on the outside and cannot #4. The mittens cannot more than 1 hour 15 sak for 15 minutes. Use of evice is to be recorded on heet. he physician orders dated vealed he is prescribed eral times daily to address avior and Trazedone 100mg. n Rights Committee (HRC) use of this behavioral e of Seroquel and #4 had not been discussed eting was held on 4/10/18 admitted. with the qualified intellectual lal (QIDP) revealed he had C chairperson by phone or ave these restrictions #4's admission on 5/21/18. eview client #6's restrictions c medication, medication echniques used to address aviors at mealtime. 	W 262			

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	-					FORM	07/06/2018 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		34G257	B. WING		_	07/0	03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MIDLAKE	RESIDENTIAL			68 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 262	direct care staff. Interview on 7/3/18 wi disabilities profession is seated at the kitche safety and environme	ith the qualified intellectual al (QIDP) revealed client #6 en ledge at mealtimes for ental reasons due to her	W 262	2			
	prescribed pureed die safety concerns regar behavior and rapid pa	taffing and her need for a et texture. This also involves rding her inappropriate ace of eating at mealtime.					
	behavior support plan address her target be behavior, aggression, toileting accidents, Plu make responsible cho	CA, spitting and failure to					
	dated 5/16/18 reveale 300 mg. (1) TID, Sero 50 mg. (1) at 5pm and Clonazepam 2 mg. (1 Lorazepam 3 mg.one	client #6's physician orders ed she receives Gabapentin oquel 300mg. (1) Seroquel d Seroquel 50 mg. at 8am,) TID, Diazepam 5 mg. and hour prior to dental edone 100 mg. at night for					
	7/17/17, 10/25/17 and discussion of the psyc client #6 and no discu restrictions involving t #6 during mealtime fro	he HRC meeting minutes for d 4/10/18 involved no chotropic medications for ussion of the mealtime techniques to separate client om the other clients due to ed to her inappropriate					
	Review on 7/3/18 of c	client #6's BSP dated 8/4/17					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		D. 0938-03 E SURVEY
		IDENTIFICATION NUMBER:		3		PLETED
		34G257	B. WING		07	/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE	RESIDENTIAL			68 HILLSIDE STREET CLARKTON, NC 28433		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
W 262	Continued From page	8	W 26	2		
		airperson had given written this program on 8/4/17.				
	had been no discussi since 8/4/17 of enviro	ith the QIDP revealed there on at the HRC meetings onmental restrictions at ed BSP for client #6 which				
W 263	included the use of pa	sychotropic medication. RING & CHANGE	W 26	3		
	are conducted only w	d insure that these programs ith the written informed parents (if the client is a an.				
	Based on observatio interview, the facility f behavior support plan the written informed o	ted 2 of 4 audit clients (#4,				
	1. The qualified intelle professional (QIDP) fa informed consent for medication and use o	ailed to obtain written client #4's psychotropic				
	were observed applyi mittens to client #4's	self-injury to his head. Client				
		lient #4's record revealed e facility on 5/21/18. Further				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/06/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		34G257	B. WING			_	07/	03/2018
NAME OF PI	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MIDLAKE	RESIDENTIAL				68 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 263	guardian had been as by the court. Review plan (IPP) revealed hy self-injurious behavior behavior guidelines. F behavior guidelines d included the use of a mittens that were to a hit himself or tries to p mittens are to applied outside and cannot be mittens cannot remain hour 15 minutes witho Use of this non-contir recorded on the beha Review on 7/3/18 of tt 6/5/18 for client #4 re Seroquel 50 mg. seve his inappropriate beha at night for sleep. Interview on 7/3/18 w had not obtained writt client #4's legal guard psychotropic medicat mitten use. Additional been mailed but had no date. Additional interview behavior support plan was dated 6/25/18, ho program could not be received written conse until a date could be a Psychologist to inservi facility.	ad been adjudicated and a asigned to act on his behalf of his individual program e has target behaviors of r which was addressed by Further review of the ated 5/24/18 revealed this non-contingent device using upplied when he attempts to boke himself in the eye. The I by staff and tie on the e removed by client #4. The n on his hands more than 1 but a break for 15 minutes. Angent device is to be vioral data sheet. The physician orders dated vealed he is prescribed eral times daily to address avior and Trazedone 100mg. The the QIDP revealed he ten informed consent from tian for the use of ions or the use of restrictive i interview revealed this had not been received as of this view revealed a new n had been developed which owever he stated this implemented until he ent from the guardian and	W	263	3			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G257 B. WING 07/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **68 HILLSIDE STREET** MIDLAKE RESIDENTIAL CLARKTON, NC 28433 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 263 Continued From page 10 W 263 consent from client #6's legal guardian for her active treatment program which included the use of psychotropic medication. Review on 7/3/18 of client #6's record confirmed she had been adjudicated incompetent and a legal guardian was assigned by the court to act on her behalf. Review on 7/3/18 of client #6's record revealed a behavior support plan (BSP) dated 8/4/17 to address her target behaviors of severe disruptive behavior, aggression, property destruction, toileting accidents, PICA, spitting and failure to make responsible choices. The use of psychotropic medications is included in this program. The consent page at the back of this program did not include the legal guardians signature. The behavior support program was signed by the QIDP, the Psychologist and the human rights committee on 8/4/17. Review on 7/3/18 of client #6's physician orders dated 5/16/18 revealed she receives Gabapentin 300 mg. (1) TID, Seroquel 300mg. (1) Seroquel 50 mg. (1) at 5pm and Seroquel 50 mg. at 8am, Clonazepam 2 mg. (1) TID, Diazepam 5 mg. and Lorazepam 3 mg.one hour prior to dental procedures and Trazedone 100 mg. at night for sleep. Interview on 7/3/18 with the QIDP revealed he had been unable to obtain written informed consent from client #6's legal guardian for her behavior support program (BSP) to address her target behaviors dated 8/4/17. W 288 MGMT OF INAPPROPRIATE CLIENT W 288 **BEHAVIOR**

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/06/2018

	-	D HUMAN SERVICES				FORM	0: 07/06/2018 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		34G257	B. WING		_	07/	03/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MIDLAKE	RESIDENTIAL			8 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	an active treatment pro- This STANDARD is r Based on observation interviews, the team f to manage inappropri- as a substitute for act sampled clients (#6) r from the other clients A technique separation not included in client a program (BSP). During observations of 12:08pm, client #6 was kitchen ledge eating lu 1:1 with her assisting a spoon and drinking built up sectioned plat utensils. Her food tex 5 clients were seated direct care staff. During observations of 7/2/18 and on 7/3/18 also seated at the kitc 1:1 direct care staff as mealtime. During both were seated at the dir care staff. Interview on 7/2/18 w) e inappropriate client be used as a substitute for rogram. not met as evidenced by: ns, record review and ailed to assure techniques ate behavior were not used ive treatment for 1 of 3 elative to separating her at mealtime. The finding is: ng client #6 at mealtime was #6's behavior support of lunch on 7/2/18 at as seated in a chair at the unch. Direct care staff was her scooping her food using from a cup. She utilized a te and regular cups and ture was pureed. The other in the dining room table with	W 288				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/06/2018 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING			07/	/03/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE	RESIDENTIAL				18 HILLSIDE STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 288	to reach for the other interview revealed her pureed and consumin other than her prescri to her and can be disr Review on 7/3/18 of co plan (IPP) dated 6/28/ 8/4/17 that addresses aggression, property of accidents and PICA. If and the BSP revealed separating client #6 in room and kitchen duri inappropriate behavio Interview on 7/3/18 w technique of separatin due to her need for a texture and that she w clients food at the dini interview revealed clie rapid pace and has 1: QIDP confirmed this to mealtime from the oth client #6's BSP. DRUG USAGE CFR(s): 483.450(e)(2 Drugs used for contro must be used only as client's individual prog specifically towards th	she will sometimes attempt client's food. Further r food texture is to be ag another food texture, bed diet, poses a safety risk ruptive during mealtime. client #6's individual program /18 revealed a BSP dated a severe disruptive behavior, destruction, toileting Further review of the IPP d no information regarding n another area of the dining ing mealtimes due to her ors. with the QIDP revealed the ng client #6 at mealtime is prescribed puree diet will attempt to grab other ing room table. Additional ent #6 attempts to eat at a :1 staffing at meals. The rechnique to separate her at her clients is not included in		288			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/06/2018 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		34G257	B. WING		_	07/0	03/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
MIDLAKE	RESIDENTIAL			8 HILLSIDE STREET LARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 312	This STANDARD is r Based on record revi failed to assure all me control were integrate program for 1 of 3 aud is: The qualified intellectr (QIDP) failed to ensur program was develop his inappropriate beha use of psychotropic m Review on 7/3/18 of tt 6/5/18 for client #4 rev Seroquel several time inappropriate behavion night for sleep. Interview on 7/3/18 w behavior support plan which was dated 6/25 program could not be received written conse stated it would also b Psychologist to inserv facility. Further intervi have written consent therefore the behavio #4 had not been imple SPACE AND EQUIPM CFR(s): 483.470(g)(1 The facility must prov equipment in dining, I recreation, and progr	tot met as evidenced by: ew and interview, the facility edications used for behavior d into an active treatment dit clients (#4) . The finding ual disabilities professional re an active treatment ed for client #4 to address aviors which included the hedication. The physician orders dated vealed he is prescribed as daily to address his r and Trazedone 100mg. at ith the QIDP revealed a new (BSP) had been developed /18, however he stated this implemented until he en ecessary for the tice direct care staff at the ew confirmed he did not for this program and r support program for client emented. MENT) ide sufficient space and iving, health services, am areas (including and sound treated areas for	W 312				

Facility ID: 922227

If continuation sheet Page 14 of 17

	-	ID HUMAN SERVICES					FORM	07/06/2018 APPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G257	B. WING				07/	03/2018
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COD	θE		
MIDLAKE	RESIDENTIAL				8 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
W 435	clients with needed se subpart and as identif program plan. This STANDARD is n Based on observation review, the facility fail	e 14 ity) to enable staff to provide ervices as required by this fied in each client's individual not met as evidenced by: ns, interviews and record ed to ensure sufficient able to enable direct care	w	435				
	staff to provide 2 of 3 non-audit client (#1) w identified by the indivi The finding is: The facility failed to pr	audit clients (#5, #6) and with needed services as idual program plan (IPP). rovide a variety of working 2 of 3 audit clients and one						
	4:48pm, direct care st non audit client #1. Cl and tried to activate th was not working. Dire it isn't working. I gues	n the facility on 7/2/18 at taff offered a talking book to lient #1 flipped the pages he sound for this book but it ect care staff told her, "Sorry, as the batteries are dead." book on the couch and got activity.						
	5:05pm, direct care st wanted to play with th leisure closet. Anothe overheard to tell her,	n the facility on 7/2/18 at taff asked client #5 if she he connect four game in the er direct care staff was "The connect four game is to do something else."						
	6:42am, direct care st activated book. Direct	n the facility on 7/3/18 at taff offered client #6 a sound t care staff tried to activate would not activate, staff						

Facility ID: 922227

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				FORM	D: 07/06/2018
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
34G257	B. WING _			07/	03/2018
	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
different types of safety the leisure closet at the vith bubbles, a broken minton set with missing vith missing pieces, a halk, and several fety devices to activate. t #6's individual program ndicates she has s. t #6's behavior support er prevention of on page 5, "[Client #6] n she is prompted to d activity. Therefore, as hould provide [client #6] ner to engage in t #5's IPP dated 4/1/18 al but communicates by lirect care staff revealed non-verbal but they are s when provided s. Further interview cility's leisure activities epair. Additional ere not certain who was g leisure materials. the qualified intellectual QIDP) revealed clients	W 2	135			
	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G257 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) different types of safety the leisure closet at the rith bubbles, a broken minton set with missing with missing pieces, a nalk, and several fety devices to activate. t #6's individual program ndicates she has s. t #6's behavior support er prevention of on page 5, "[Client #6] n she is prompted to d activity. Therefore, as hould provide [client #6] ner to engage in t #5's IPP dated 4/1/18 al but communicates by lirect care staff revealed non-verbal but they are s when provided 5. Further interview cility's leisure activities epair. Additional ere not certain who was g leisure materials. he qualified intellectual	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G257 B. WING	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G257 B. WING	DicAID SERVICES PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: 346257 B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 68 HILLSIDE STREET CLARKTON, NC 28433 ENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 68 HILLSIDE STREET CLARKTON, NC 28433 ENT OF DEFICIENCIES STREET REPRECEDED BY FULL PREFIX TAG DEFICIENCY WU 435 different types of safety the leisure closet at the tith missing protection of on page 5, "[Client #6] a schitth Therefore, as tould provide [client #6] a schithy therefore, as	UMAN SERVICES FOR ICCAID SERVICES OMB NC PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER: 34G257 B. WING (2) MULTIPLE CONSTRUCTION A BUILDING (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE

Facility ID: 922227

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/06/2018 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	(X3) DATE SURVEY COMPLETED	
34G257			B. WING			07/03/2018		
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
MIDLAKE RESIDENTIAL					8 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 435	capable of making ch preferred leisure activ revealed he was unav	oices when provided vities. Further interview ware that several of the the clients in the facility	W	435				

Facility ID: 922227

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