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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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[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: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 7/2/18 of the facility's emergency preparedness (EP) plan (revised 5/21/18) did not include any information regarding alternate means of communication. During an interview on 7/2/18, staff stated they were unaware of any alternate communication system to utilize in the event of an emergency with the exception of personal cellphones.	E 032	E 032 The facility will develop specific policies and procedures to address emergency preparedness specific to to including a facility and community-based risk assessment utilizing all hazards approach. The team will complete a facility and community based risk assessment to update/revise current emergency preparedness plan. The information will be specific to the facilities level of risk such as in the case of flood, fire, tornadoes, hurricanes, winter storms and bio-terrorism. The team will monitor monthly and make annual updates.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Chris Shumaker, ICF Division Director — 8-17-18

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.

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E 032	Continued From page 1 During an interview on 7/3/18, the qualified intellectual disabilities professional (QIDP) stated an in regards to an alternate mean of communication "nothing has been put in place."	E 032		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to include specific information in 1 of 3 audit client's (#6) individual program plan (IPP) specific to behavioral/environmental modifications to address her behaviors during mealtime. The findings include: Client #6's IPP and behavior support plan (BSP) did not include specific information about strategies used during mealtime to address her inappropriate behavior. During observations of lunch on 7/2/18 at 12:08pm, client #6 was seated in a chair at the kitchen ledge eating lunch. Direct care staff was 1:1 with her assisting her scooping her food using a spoon and drinking from a cup. She utilized a built up sectioned plate and regular cups and utensils. Her food texture was pureed. The other 5 clients were seated in the dining room table with direct care staff. During observations on 7/2/18 at supper on	W 240	W240- The facility will ensure that all IPP's include specific information to support their independence during dinning. QP will update/revise client#6 IPP and BSP to include sitting with peers one day out of the week. Program Manager will monitor weekly and QP will monitor monthly.	

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W 240	Continued From page 2 7/2/18 and on 7/3/18 at breakfast client #6 was also seated at the kitchen ledge in a chair with 1:1 direct care staff assisting her during mealtime. During both meals, the other 5 clients were seated at the dining room table with direct care staff. Interview on 7/2/18 with direct care staff revealed client #6 was seated in the kitchen away from the other clients because she will sometimes attempt to reach for the other client's food. Further interview revealed her food texture is to be pureed and consuming another food texture, other than her prescribed diet, poses a safety risk to her and can be disruptive during mealtime. Review on 7/3/18 of client #6's IPP dated 6/28/18 revealed she is prescribed a heart healthy diet with a pureed diet texture. Further review of the IPP revealed client #6 uses a built up sectioned plate and that she "eats family style dining and eats independently." Review on 7/3/18 of client #6's BSP dated 8/4/17 addresses severe disruptive behavior, aggression, property destruction, toileting accidents and PICA. Further review of the IPP and the BSP revealed no information regarding separating client #6 in another area of the dining room and kitchen during mealtimes due to her inappropriate behaviors. Interview on 7/3/18 with the qualified intellectual disabilities professional (QIDP) revealed there is no information in the IPP or the BSP for client #6 regarding separating her from the other clients in the facility during mealtimes. Further interview confirmed client #6 is seated at the kitchen ledge at mealtimes for safety and environmental	W 240		

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W 240	Continued From page 3 reasons due to her need for increased staffing and safety concerns at mealtime.	W 240		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interview the interdisciplinary team failed to ensure objective training to meet identified needs relative to toileting were implemented for 1 of 3 audit clients (#4). The finding is: Client #4's interdisciplinary team failed to establish training in the area of toileting to address his personal care needs. During observations in the facility on 7/2/18 at 11:55am, the top of client #4's disposable brief could be seen at the top of his shorts while he walked through the living room area of the facility. Direct care staff stopped him and readjusted his clothing so his shirt covered the top of his shorts. Interview on 7/2/18 with direct care staff revealed client #4 is incontinent of bowel and bladder and wears disposable briefs throughout the day and night. Further interview revealed he is not on a	W 242	W 249 The facility will ensure that individuals receive training in the area of toileting, personal hygiene, self-feeding,bathing, grooming, and communication. Life Skills Specialist will assess client #4's toileting skills and develop a toileting goal specific to his needs. Program Manager and Life Skills Specialist will monitor weekly. QP will monitor monthly.	

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W 242	Continued From page 4 toileting schedule. Review on 7/3/18 of client #4's record revealed client #4 was admitted to the facility on 5/21/18. Review of his individual program plan (IPP) dated 6/22/18 revealed he is incontinent of bowel and bladder and wears disposable briefs throughout the day and night. Further interview revealed there was not any objective training considered for client #4 to make him more independent in this area. Interview on 7/3/18 with the qualified intellectual disabilities professional (QIDP) revealed client #4 is incontinent of bowel and bladder, wears disposable briefs and is checked every 2 hours for toileting accidents. Further interview there was no consideration by the interdisciplinary team to establish any objective training in the area of toileting for client #4. Additional interview revealed he has not been evaluated by his physician to determine if there is any medical reason he cannot be trained in the area of toileting.	W 242		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the restrictive behavior support plans (BSP) for 2 of 4	W 262	W262- The facility will ensure that all BSP's are reviewed by the Human Rights Committee. QP will have client#4, #6 BSP's reviewed by the Human Rights Committee. QP will monitor monthly.	

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W 262	Continued From page 5 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	W 262		

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W 262	Continued From page 6	W 262		

applied by staff and tie on the outside and cannot be removed by client #4. The mittens cannot remain on his hands more than 1 hour 15 minutes without a break for 15 minutes. Use of this non-contingent device is to be recorded on the behavioral data sheet.

Review on 7/3/18 of the physician orders dated 6/5/18 for client #4 revealed he is prescribed Seroquel 50 mg. several times daily to address his inappropriate behavior and Trazedone 100mg. at night for sleep.

Review of the Human Rights Committee (HRC) minutes revealed the use of this behavioral restriction and the use of Seroquel and Trazedone for client #4 had not been discussed by HRC. The last meeting was held on 4/10/18 before client #4 was admitted.

Interview on 7/3/18 with the qualified intellectual disabilities professional (QIDP) revealed he had not contacted the HRC chairperson by phone or correspondence to have these restrictions reviewed since client #4's admission on 5/21/18.

2. The HRC did not review client #6's restrictions involving psychotropic medication, medication utilized for sleep or techniques used to address her inappropriate behaviors at mealtime.

During observations of lunch on 7/2/18 at 12:08pm, client #6 was seated in a chair at the kitchen ledge eating lunch. Direct care staff was 1:1 with her assisting her scooping her food using a spoon and drinking from a cup. She utilized a built up sectioned plate and regular cups and utensils. Her food texture was pureed. The other 5 clients were seated in the dining room table with

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W 262	Continued From page 7 direct care staff. Interview on 7/3/18 with the qualified intellectual disabilities professional (QIDP) revealed client #6 is seated at the kitchen ledge at mealtimes for safety and environmental reasons due to her needs for increased staffing and her need for a prescribed pureed diet texture. This also involves safety concerns regarding her inappropriate behavior and rapid pace of eating at mealtime. 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. 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. Review on 7/3/18 of the HRC meeting minutes for 7/17/17, 10/25/17 and 4/10/18 involved no discussion of the psychotropic medications for client #6 and no discussion of the mealtime restrictions involving techniques to separate client #6 during mealtime from the other clients due to safety concerns related to her inappropriate behaviors. Review on 7/3/18 of client #6's BSP dated 8/4/17	W 262		

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W 262	Continued From page 8 revealed the HRC chairperson had given written informed consent for this program on 8/4/17. Interview on 7/3/18 with the QIDP revealed there had been no discussion at the HRC meetings since 8/4/17 of environmental restrictions at mealtime, the continued BSP for client #6 which included the use of psychotropic medication.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure restrictive behavior support plans were only conducted with the written informed consent of all legal guardians. This affected 2 of 4 audit clients (#4, #6). The findings are: 1. The qualified intellectual disabilities professional (QIDP) failed to obtain written informed consent for client #4's psychotropic medication and use of restrictive mittens. During observations on 7/2/18 and on 7/3/18 staff were observed applying and removing restrictive mittens to client #4's hands when he would attempt to engage in self-injury to his head. Client #4 was unable to remove these mittens. Review on 7/2/18 of client #4's record revealed he was admitted to the facility on 5/21/18. Further	W 263	W263- The facility will ensure all clients informed consents are completed and signed. (1,2)QP will obtain written informed consents for medication and the use of mittens for client#4 and written informed consent for medication for client#6. QP will monitor monthly.	

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W 263	Continued From page 9	W 263		

review revealed he had been adjudicated and a guardian had been assigned to act on his behalf by the court. 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 applied by staff and tie on the outside and cannot be removed by client #4. The mittens cannot remain on his hands more than 1 hour 15 minutes without a break for 15 minutes. Use of this non-contingent device is to be recorded on the behavioral data sheet.

Review on 7/3/18 of the physician orders dated 6/5/18 for client #4 revealed he is prescribed Seroquel 50 mg. several times daily to address his inappropriate behavior and Trazedone 100mg. at night for sleep.

Interview on 7/3/18 with the QIDP revealed he had not obtained written informed consent from client #4's legal guardian for the use of psychotropic medications or the use of restrictive mitten use. Additional interview revealed this had been mailed but had not been received as of this date. Additional interview revealed a new behavior support plan had been developed which was dated 6/25/18, however he stated this program could not be implemented until he received written consent from the guardian and until a date could be arranged for the Psychologist to inservice direct care staff at the facility.

2. The QIDP did not obtain written informed

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W 263	Continued From page 10 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 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 288		

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W 288	Continued From page 11 CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the team failed to assure techniques to manage inappropriate behavior were not used as a substitute for active treatment for 1 of 3 sampled clients (#6) relative to separating her from the other clients at mealtime. The finding is: A technique separating client #6 at mealtime was not included in client #6's behavior support program (BSP). During observations of lunch on 7/2/18 at 12:08pm, client #6 was seated in a chair at the kitchen ledge eating lunch. Direct care staff was 1:1 with her assisting her scooping her food using a spoon and drinking from a cup. She utilized a built up sectioned plate and regular cups and utensils. Her food texture was pureed. The other 5 clients were seated in the dining room table with direct care staff. During observations on 7/2/18 at supper on 7/2/18 and on 7/3/18 at breakfast client #6 was also seated at the kitchen ledge in a chair with 1:1 direct care staff assisting her during mealtime. During both meals, the other 5 clients were seated at the dining room table with direct care staff. Interview on 7/2/18 with direct care staff revealed client #6 is seated in the kitchen away from the	W 288	W288- The facility will ensure that techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. QP will meet with Psychologist and update/revise client#6 BSP. QP will monitor monthly.	

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W 288	Continued From page 12 other clients because she will sometimes attempt to reach for the other client's food. Further interview revealed her food texture is to be pureed and consuming another food texture, other than her prescribed diet, poses a safety risk to her and can be disruptive during mealtime. Review on 7/3/18 of client #6's individual program plan (IPP) dated 6/28/18 revealed a BSP dated 8/4/17 that addresses severe disruptive behavior, aggression, property destruction, toileting accidents and PICA. Further review of the IPP and the BSP revealed no information regarding separating client #6 in another area of the dining room and kitchen during mealtimes due to her inappropriate behaviors. Interview on 7/3/18 with the QIDP revealed the technique of separating client #6 at mealtime is due to her need for a prescribed puree diet texture and that she will attempt to grab other clients food at the dining room table. Additional interview revealed client #6 attempts to eat at a rapid pace and has 1:1 staffing at meals. The QIDP confirmed this technique to separate her at mealtime from the other clients is not included in client #6's BSP.	W 288		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	W 312	W312-The facility will assure that all medications used for behavior control were integrated into an active treatment program. QP will have client#4's BSP signed by guardian and inservice all staff members. QP will monitor monthly.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G257	A. BUILDING _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAKE RESIDENTIAL	68 HILLSIDE STREET CLARKTON, NC 28433

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W 312	Continued From page 13 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure all medications used for behavior control were integrated into an active treatment program for 1 of 3 audit clients (#4) . The finding is: The qualified intellectual disabilities professional (QIDP) failed to ensure an active treatment program was developed for client #4 to address his inappropriate behaviors which included the use of psychotropic medication. Review on 7/3/18 of the physician orders dated 6/5/18 for client #4 revealed he is prescribed Seroquel several times daily to address his inappropriate behavior and Trazedone 100mg. at night for sleep. Interview on 7/3/18 with the QIDP revealed a new behavior support plan (BSP) had been developed which was dated 6/25/18, however he stated this program could not be implemented until he received written consent from the guardian. He stated it would also be necessary for the Psychologist to inservice direct care staff at the facility. Further interview confirmed he did not have written consent for this program and therefore the behavior support program for client #4 had not been implemented.	W 312		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are	W 435	W 435 The facility will provide sufficient space and equipment for leisure material to follow each individuals IPP plan. Program Manager will inservice staff with activities weekly. QP will monitor monthly.	

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W 435	Continued From page 14 conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure sufficient equipment was available to enable direct care staff to provide 2 of 3 audit clients (#5, #6) and non-audit client (#1) with needed services as identified by the individual program plan (IPP). The finding is: The facility failed to provide a variety of working leisure materials for 2 of 3 audit clients and one non-audit client. During observations in the facility on 7/2/18 at 4:48pm, direct care staff offered a talking book to non audit client #1. Client #1 flipped the pages and tried to activate the sound for this book but it was not working. Direct care staff told her, "Sorry, it isn't working. I guess the batteries are dead." Client #1 dropped the book on the couch and got up to look for another activity. During observations in the facility on 7/2/18 at 5:05pm, direct care staff asked client #5 if she wanted to play with the connect four game in the leisure closet. Another direct care staff was overheard to tell her, "The connect four game is broken, you will have to do something else." During observations in the facility on 7/3/18 at 6:42am, direct care staff offered client #6 a sound activated book. Direct care staff tried to activate the book and when it would not activate, staff	W 435	The facility will provide client's #1,#4 and #6 with working leisure activities that do not have missing pieces. Program manager and Life Skills Specialist will monitor weekly and QP will monitor monthly	

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W 435	Continued From page 15	W 435		

reached for a puzzle with different types of safety locks.

Observation on 7/2/18 of the leisure closet at the facility revealed a bottle with bubbles, a broken connect four game, a badminton set with missing pieces, a tabletop game with missing pieces, a container with sidewalk chalk, and several puzzles with locks and safety devices to activate.

Review on 7/3/18 of client #6's individual program plan (IPP) dated 6/28/18 indicates she has strengths to make choices.

Review on 7/3/18 of client #6's behavior support plan (BSP) revealed under prevention of inappropriate behaviors on page 5, "[Client #6] spitting may surface when she is prompted to engage in a non-preferred activity. Therefore, as much as possible, staff should provide [client #6] choices when prompting her to engage in activities or programs."

Review on 7/3/18 of client #5's IPP dated 4/1/18 revealed she is non-verbal but communicates by facial expressions.

Interview on 7/2/18 with direct care staff revealed clients #1, #5 and #6 are non-verbal but they are capable of making choices when provided preferred leisure activities. Further interview revealed several of the facility's leisure activities are broken or in need of repair. Additional interview revealed they were not certain who was responsible for purchasing leisure materials.

Interview on 7/3/18 with the qualified intellectual disabilities professional (QIDP) revealed clients #1, #5 and #6 are non-verbal but they are

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W 435	Continued From page 16 capable of making choices when provided preferred leisure activities. Further interview revealed he was unaware that several of the leisure items used for the clients in the facility were broken or in need of being replaced.	W 435		