DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	08/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body failed to ensure furniture in the home was clean, sanitary and maintained in good condition. The finding is: Furniture was soiled, stained and worn. During observations in the home throughout the survey on 8/12 - 8/13/19, a chair in the living room was severely stained with a large discolored circle covering the entire seat cushion of the chair, the front of the chair and another large dark stain on the upper right side of back of the chair. The seat cushion was also misshaped with thin creases throughout. Interview on 8/13/19 with Staff D revealed the furniture in the living room had been in the home for less than a year and the stained chair was mainly utilized by one client in the home. Additional interview indicated the client frequently had toileting accidents in the chair and since the pillows cannot be removed, the chair was very hard to clean. Interview on 8/13/19 with the Home Supervisor and Qualified Intellectual Disabilities Professional (QIDP) revealed the living room furniture was purchased by a former management staff and was not appropriate for the home since the cushions are not covered or removable.	W 104	W 104 The facility will ensure that the governing body exercise general policy, budget and operating direction over the facility. The facility will ensure that all homes have clean, sanitary and maintained furniture in the home. The Group Home Manager will submit a work order for new furniture and ensure that the furniture being order is adequate and sufficient for the individuals within the home. The manager will check furniture weekly for damage and ensure staff is cleaning appropriately. The Clinical Supervisor will monitor monthly.	10/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Williams | TITLE: Clinical Supervisor | (X6) DATE: 8/21/19

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 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.

RECEIVED
By DHRS-Mental Health Licensure at 2:04 pm, Sep 03, 2019

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MIDLAKE RESIDENTIAL	69 HILLSIDE STREET CLARKTON, NC 28433

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W 104	Continued From page 1 Additional Interview confirmed the chair has been urinated on and is hard to clean.	W 104		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1's Individual Program Plan (IPP) included objectives to meet her needs. This affected 1 of 5 audit clients. The finding is: Client #1's IPP did not include formal objectives to address her vocational needs. Review on 8/12/19 of client #1's IPP dated 6/9/19 revealed objectives to exercise, floss her teeth, identify foods and sweep the floor. The plan also included the following educational/vocational needs: learn to identify numbers, learn to identify colors, learn to keep up with her money, learn to identify coins, learn to identify her name, improve sorting skills, money management/purchasing skills, improve counting/writing skills, package items independently, increase time on task and expand survival skills knowledge. Additional review of the IPP did not include objectives to address client #1's educational/vocational needs. Interview on 8/13/19 with the Home Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 continues to have	W 227	**W 227** The facility will ensure that all individuals program plan states specific objectives necessary to meet the client's needs as identified by the comprehensive assessments. The Habilitation Specialist will develop goals specific to client needs based of their assessments. The Habilitation Specialist will develop a vocational goal for client #1 and in-service staff on new goals. Habilitation Specialist and Program Manager will monitor weekly and Clinical Supervisor will monitor monthly.	10/11/19

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W 227	Continued From page 2 vocational needs; however, no current objectives have been implemented.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 3 of 5 audit clients (#1, #2, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of self-help skills, objective implementation and participation with administration of medications. The findings are: 1. Client #1 was not provided edible reinforcers as indicated in her Behavior Support Plan (BSP). During meal preparation observations in the home at dinner on 8/12/19 and breakfast on 8/13/19, Staff F and Staff E provided client #1 with various amounts of Skittles candy on several occasions as she completed tasks in the kitchen. Interview on 8/13/19 with Staff E revealed the candy was given to client #1 as a reward for good	W 249	**W 249** The facility's interdisciplinary team will ensure that all individuals receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual's program plan. The Clinical Supervisor will In service all staff on client #1 Behavior Support Plan and ensure that appropriate edible reinforcers are being used, and ensure all staff are aware of when reinforcers are used based off the BSP.	10/11/19

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W 249	Continued From page 3 behavior while assisting in the kitchen. Review on 8/13/19 of client #1's BSP dated 4/1/19 revealed,"[Client #1] will receive a reinforcer for initiating and completing tasks, for participation in leisure, self-help or vocational activities and for not exhibiting any challenging behavior. Reinforcers can include low calorie edible (for example, diet candy, fruit, etc) or low calorie beverage." Interview on 8/13/19 with the Home Supervisor and Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #1 should be offered low calorie snacks which should not include regular candy. 2. Client #2 did not participate with the administration of his medications as indicated. During observations of medication administration in the home on 8/12/19 at 3:37pm and 8/13/19 at 7:18am, client #2 was assisted to pour his water and consume his pills. The client was not prompted or assisted to place his pills into a pill cup. Interview on 8/12/19 and 8/13/19 with medication technicians, Staff B and Staff C revealed what was observed is how client #2 normally participates during the medication pass. Staff B indicated clients are assisted to be as independent as possible during the administration of their medications. Review on 8/13/19 of client #2's IPP dated 4/14/19 revealed a strength to assist with taking medications by placing pills in a pill cup after the packet is opened by staff and pouring his water.	W 249	The Habilitation Specialist will develop a goal for client #2 to allow him to participate in his medication administration to the highest of his ability. The Habilitation Specialist will in-service staff on new goal and appropriate way to train goal. The Habilitation Specialist and Program Manager will monitor goal weekly and Clinical Supervisor will monitor monthly.	

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W 249	Continued From page 4 The plan noted, "Staff will continue to encourage [Client #2] to be as independent as possible throughout his daily routine." During an interview on 8/13/19, the Home Supervisor acknowledged client #2 could likely assist with putting his pills in a bowl during the medication pass. 3. Clients (#2, #5) were not prompted or assisted to set their place at the table. During observations in the home on 8/12/19 at 5:08pm, several clients were prompted and assisted to set their place at the table for dinner. During this time, client #2's place setting was set for him without prompting him to participate with this task. During observations in the home on 8/13/19 at 7:01am, several clients were prompted and assisted to set their place at the table for breakfast. During this time, client #5's place setting was set for her without prompting her to participate with this task. Review on 8/13/19 of client #2's IPP dated 4/14/19 revealed a need to "learn to set table." The plan also noted, "Staff will continue to encourage [Client #2] to be as independent as possible throughout his daily routine." Review on 8/13/19 of client #5's Adaptive Behavior Inventory (ABI) dated 6/18/19 revealed the client is partially independent with setting the table. Additional review of the IPP dated 6/20/19 indicated, "[Client #5] is encouraged to be as independent as possible throughout her daily routine."	W 249	The Habilitation Specialist will develop goals for clients #2 and #5 to ensure that they are participating with meal place setting to their fullest potential. The Habilitation Specialist will in service staff on appropriate way to train goal. The goal will be monitored weekly by Habilitation Specialist and Program Manager. Clinical Supervisor will monitor monthly.	

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W 249	Continued From page 5 Interview on 8/13/19 with the Home Supervisor confirmed client #2 and client #5 can participate with setting their place at the table given staff assistance.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure data relative to criteria specified in client #3's Individual Program Plan (IPP) objectives was documented in measurable terms. This affected 1 of 5 audit clients. The finding is: Data relative to client #3's Behavior Support Plan (BSP) was not collected as indicated. During observations in the home and at the day program throughout the survey on 8/12 - 8/13/19, various staff utilized soft gloves/mittens secured to client #3's hands to address his self-injurious behaviors. Each time the client hit himself on or about his face, the restrictive gloves were applied. Review on 8/13/19 of client #3's BSP dated 6/5/19 revealed an objective to address inappropriate behaviors of aggression, property destruction, severe disruption, self-injurious	W 252	W 252 The facility will ensure that data relative to criteria specified in client's Individual Program Plan objectives is documented in measurable terms. Clinical Supervisor will in service all staff on client #3 Behavior Support Plan relating to usage of soft gloves/mittens during self-injurious behaviors. Clinical Supervisor will provide a documentation sheet for glove usage when behaviors occur. Program Manager will monitor weekly and Clinical Supervisor will monitor monthly.	10/11/19

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W 252	Continued From page 6 behavior (SIB) and failure to make responsible choices. Additional review of the plan indicated the use of protective gloves as an intervention to address incidents of SIB. The plan noted, "If [Client #3] exhibits SELF-INJURIOUS BEHAVIOR...staff will immediately place the Protective Restraint Device (specifically, the Protective Gloves) on his hands. The Protective Gloves will remain on his hands for one hour and fifty (1' 50") minutes. The gloves will then remain off for ten (10) consecutive minutes." Further review of the BSP under documentation revealed, "Use of the Protective Gloves will also be documented on the 'Contingent Restraint Device Data Sheet." Review on 8/13/19 of client #3's objective training book did not include any documentation of the use of his protective gloves. Interview on 8/13/19 with the Home Supervisor confirmed client #3 wears the protective gloves to address SIB and the gloves should not be worn for longer than 1 hour and 50 minutes. Additional interview indicated no documentation for use of the gloves as noted in the BSP was currently being kept.	W 252		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all	W 369	**W 369** The facility will ensure that the system for all drug administration including those that are self-administered and ensure administered without error for all individuals.	10/11/19

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W 369	Continued From page 7 medications were administered without error. This affected 1 of 2 clients (#2) observed receiving medications. The finding is: Client #2 did not receive his Flonase as indicated. During observations of medication administration in the home on 8/13/19 at 7:18am, client #2 ingested 15 different medications and Artificial Tears eye drops were also administered in both his eyes. The client did not have nasal spray administered at this time. Review on 8/13/19 of client #2's physician's orders dated 8/1/19 - 7/31/20 revealed an order for Flonase .05% nasal spray, use 2 sprays in each nostril daily, 8:00am. Interview on 8/13/19 with the Home Supervisor confirmed client #2 continues to receive Flonase nasal spray each morning at 8:00am.	W 369	The facility Nurses will in service all staff on correct medication administration procedures of all medications prescribed by physicians for client #4. The Nurses and Program Manager will monitor weekly and Clinical Supervisor will monitor monthly.	
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 audit clients (#2, #4) received their modified and specially-prescribed diets as indicated. The findings are: 1: Client #4's modified diet was not followed at lunch and breakfast.	W 460	W 460 The facility will ensure that all clients receive a nourishing, well balanced diet including modified and specially prescribed diets.	10/1/19

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W 460	Continued From page 8 During lunch observations at the day program on 8/12/19 at 12:08pm, Staff A heated client #4's lunch plate and presented it to her in the classroom. The food items included chicken, yellow rice and green beans. Closer observation of the food revealed all items were finely ground, dry, and chunky. Client #4 consumed the food without difficulty. During breakfast observations at the home on 8/13/19 at 7:35am, client #4 consumed French toast sticks, boiled eggs and oatmeal. Closer observation of the food items revealed the toast and eggs were moist and pureed while the oatmeal was dry, thick and chunky. Client #4 consumed all food items without difficulty. Interview on 8/12/19 with Staff A revealed the lunch plate was prepared at client #4's home and only heated at the day program. Additional interview indicated client #4 receives a pureed diet. When asked what a pureed diet should look like, the staff had no response. Interview on 8/12/19 with Staff E, who prepared breakfast food items in the home, revealed the oatmeal had not been pureed in the food processor since it was already soft. Review on 8/13/19 of client #4's Individual Program Plan (IPP) dated 4/4/19 revealed she receives a regular Heart Healthy pureed consistency diet with thin liquids. Interview on 8/13/19 with the Home Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 consumes a pureed diet for all food items. Additional interview	W 460	Clinical Supervisor and Program Manager will inservice/review client #4 diet with staff to ensure an understanding of correct consistency based off of diet order. Program Manager will monitor weekly. Clinical Supervisor will monitor monthly.	

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W 460	Continued From page 9 Indicated the client's lunch should have been processed to the correct consistency by day program staff and the oatmeal from breakfast should have been pureed as well. 2. Client #2's modified diet was not provided at lunch. During lunch observations at the day program on 8/12/19 at 12:08pm, Staff A heated client #2's lunch plate and presented it to him. Closer observation of the food items revealed the rice and green been were of a regular consistency while the chicken was ground, dry, and thick with visible pieces of chicken. Client #2 consumed the food items without difficulty. Review on 8/12/19 of client #2's IPP dated 4/14/19 revealed he consumes a soft diet with pureed meats. Interview on 8/12/19 with Staff A revealed the lunch plate was prepared at client #2's home and only heated at the day program. Additional interview indicated client #2 receives pureed meats only and other foods are regular consistency. When asked what a pureed diet should look like, the staff had no response. Interview on 8/13/19 with the Home Supervisor and Qualified Intellectual Disabilities Professional (QIDP) confirmed only client #2's meats are pureed. Additional interview indicated the client's meat should have been processed to the correct consistency by day program staff.	W 460	Clinical Supervisor and Program Manager will inservice/review client #2 diet with staff to ensure an understanding of correct consistency based off of diet order. Program Manager will monitor weekly. Clinical Supervisor will monitor monthly.	

COMMUNITY INNOVATIONS, INC.

Whiteville Office
80 Alliance Drive
Whiteville, NC 28472

www.communityinnovations.com

FACSIMILE TRANSMISSION FORM

Date: 9/3/19

To:	Wilma Wagsley Viggs	From:	Barbara Williams
Fax:	919-715-8078	Fax:	(910) 642-8039
Phone:	919-855-3795	Phone:	910-642-8697
Re:	POC Midlake	Cc:	

Pages (including cover): 13

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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 15, 2019

Ms. Melissa Bryant, Division Director
Community Innovations, Inc.
80 Alliance Dr.
Whiteville, NC 28472

Re: Recertification Survey Completed August 12 - 13, 2019
Midlake Residential, 369 E. Green Rd., Clarkton, NC 28433
Provider Number: 34G257
MHL Number: MHL009-010
E-mail Address: mbryant@communityinnovations.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed August 13, 2019. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 11, 2019.

What to Include In the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow-up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Wilma Worsley-Diggs at 919-612-5520.

Sincerely,

Wilma Worsley-Diggs

Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File