DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COMF	SURVEY PLETED
		34G257	B. WING _				C /06/2021
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	RESIDENTIAL			68	HILLSIDE STREET		
WIDLARE	RESIDENTIAL			CL	ARKTON, NC 28433		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG					DEFICIENCY)		
E 000	Initial Comments A recertification and o	complaint survey were	EC	000			
W 104	completed on 1/6/202 NC00172065 and NC was substantiated. Do a result of the compla	21 for complaint Intakes: 00172098. The complaint eficiencies were not cited as int investigation, however d in conjunction with the	W 1	104			
		nust exercise general policy, g direction over the facility.					
	Based on observatio interviews the facility direction over the faci in the facility to ensur	failed to exercise operating lity by failing to repair floors e they were slip resistant to tiall effected all clients in the					
	dining room floor was from the wall in two d	n the facility on 1/5/21 the noted to be pulling away ifferent locations near the room and next to the ledge					
	years ago the facility hurricane and underw necessitated the clier several weeks until th She stated several m into the home, they ne	are staff A revealed several was flooded after a vent major repairs which its being relocated for the home could be repaired. onths after they moved back oticed the floors in the dining and coming up in pieces					
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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

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.

## PRINTED: 01/11/2021

TITLE

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/11/2021 APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G257	B. WING		_	( 01/	C 06/2021
NAME OF PF	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 104 W 195	around the wall. Addit several clients in the l and require assistance Interview on 1/5/21 w confirmed the dining r repaired. ACTIVE TREATMENT CFR(s): 483.440	tional interview confirmed home have gait problems we with ambulation. ith the program manager room floor needs to be T SERVICES ure that specific active	W 104				
	The team failed to: e received a continuous which includes aggres implementation of a p generic training and to the acquisition of the client to function with and independence as W249), ensure the int performed accurate a days after admission comprehensive functi areas where clients la ensure one newly adr individual program pla admission (W226) en basic skills needed to (W242), ensure the q	program of specialized and reatment directed towards behaviors necessary for the as much self-determination spossible (W196 and terdisciplinary team issessment(s) within 30 (W210), ensure the onal assessment defined acked basic skills (W224), mitted client (#2) received an an (IPP) within 30 days after sure clients were trained in become more independent ualified intellectual d as necessary programs to					

Event ID: Y9QN11

Facility ID: 922227

If continuation sheet Page 2 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/11/2021 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE COMP	LETED
		34G257	B. WING		_	( 01/	C 06/2021
NAME OF PF	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 195	resulted in the facility'	of these systemic practices	W 1	95			
W 196	ACTIVE TREATMEN CFR(s): 483.440(a)(1		W 19	96			
	treatment program, w consistent implement specialized and gener services and related subpart, that is directe (i) The acquisition of the client to function w determination and ind	ric training, treatment, health services described in this ed toward: the behaviors necessary for with as much self ependence as possible; and r deceleration of regression					
	Based on observation interview, the team fa continuous aggressive was implemented for and #5) which provide implementation of the (IPP) and intervention promoted client functi independence as pos regression of acquired A. Cross reference W ensure the interdiscip accurate assessment	iled to assure that a e active treatment program 3 of 3 audit clients (#1, #2 ed consistent individual program plan is in the facility, which on with as much					

Facility ID: 922227

If continuation sheet Page 3 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/11/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		X3) DATE S COMPLE	URVEY
		34G257	B. WING			C 01/0	6/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE		
MIDLAKE	RESIDENTIAL			38 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	E	(X5) COMPLETION DATE
W 196	<ul> <li>B. Cross Reference V ensure the comprehe (CFA) was completed after he was admitted</li> <li>C. Cross Reference V ensure one newly adr individual program pla admission.</li> <li>D. Cross reference W ensure for 1 of 3 audi program plan (IPP) in basic skill needs which dressing, and toothbrine</li> <li>E. Cross reference W develop an individual admitted client (#2) and audit clients (#2 and # continuous active treat of needed intervention in the individual progr 2 of 3 audit clients (#2 F. Cross reference W intellectual disabilities to review the written t audit clients (#1 and # INDIVIDUAL PROGR CFR(s): 483.440(c)(3)</li> <li>Within 30 days after a interdisciplinary team assessments or reass</li> </ul>	<ul> <li>V224. The facility failed to nsive functional assessment for 1 of 3 audit clients (#2) to the facility on 10/8/20.</li> <li>V226. The facility failed to mitted client (#2) received an an (IPP) within 30 days after</li> <li>V242. The facility failed to to t client (#2)'s individual cluded training to address the included bathing, toileting, ushing.</li> <li>V249. The facility failed to program plan for a newly and failed to ensure for 2 of 3 #5) that they received a atment program consisting ms and services as identified am plan (IPP). This affected 2 and #5).</li> <li>254. The qualified sprofessional (QIDP) failed raining programs for 2 of 3 #5) for over 9 months.</li> <li>AM PLAN )</li> </ul>	W 196				

Facility ID: 922227

If continuation sheet Page 4 of 21

	-	D HUMAN SERVICES					FORM	D: 01/11/2021
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G257	B. WING _			-		C 06/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MIDLAKE	RESIDENTIAL				3 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	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 210	Continued From page	- 4	W 2	210				
	Based on record revi failed to ensure the in performed accurate a days after admission. admitted audit clients Review on 1/5/21 of of he was admitted to th local rehabilitation fac record revealed a disc 10/8/20 from the reha client #2 had diagnos Intellectual disabilities Disorder, Benign Pros Schizophrenia, Atriov of a cardiac pacemak unsteadiness on feet Additional review on 1 revealed a nutrition ev which indicated client chopped diet with all 1 exceed 1/4 inch in siz needed. Review on 1/5/21 of a the facility dated 10/8. edentulous and that h had Benign Prostatic	ssessment(s) within 30 This affected 1 of 2 newly (#2). The finding is: lient #2's record revealed e facility on 10/8/20 from a ility. Additional review of his charge summary dated bilitation facility revealed es of Unspecified s, Major Depressive static Hyperplasia, entricular Block, Presence er, Muscle weakness, and Dysphagia.						
	feet and Dysphagia. Continued review on	veakness, unsteadiness on 1/5/21 of client #2's record o speech, occupational apy, habilitation or						

Facility ID: 922227

If continuation sheet Page 5 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/11/2021 1 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		34G257	B. WING		_	( 01/	C 06/2021
NAME OF PI	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	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 210	Continued From page psychological evaluat	ions.	W 210				
	and the program man interdisciplinary evalu	ations were not completed.					
W 224	disabilities profession	AM PLAN	W 224				
	Based on record revi interviews with staff, t that the comprehensiv (CFA) was completed	not met as evidenced by: ew and confirmed by he facility failed to ensure ve functional assessment for 1 of 3 audit clients (#2) the facility. The finding is:					
		lient #2's record revealed e facility on 10/8/20 from a ility.					
	revealed no comprehe assessment (CFA) to	assess client #2's lls needed to promote his					
		ith the life skills specialist nager revealed an adaptive					

Facility ID: 922227

If continuation sheet Page 6 of 21

S FOR MEDICARE & N	D HUMAN SERVICES					FORM	D: 01/11/2021 APPROVED D. 0938-0391
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE COMP	SURVEY PLETED
	34G257	B. WING			-		C 06/2021
OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
RESIDENTIAL							
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BI CED TO THE APPROPRIA		(X5) COMPLETION DATE
behavior inventory wa client #2's independer admitted to the facility Interview with the qua professional (QIDP) c for client #2 during the INDIVIDUAL PROGR CFR(s): 483.440(c)(4) Within 30 days after a interdisciplinary team	is not completed to assess int living skills after he was on 10/8/20. lified intellectual disabilities onfirmed the lack of a CFA e exit conference on 1/6/21. AM PLAN ) dmission, the must prepare, for each						
Based on observation interview, the facility fa admitted client (#2) re program plan (IPP) wi admission. The findin A. Review on 1/5/21 of he was admitted to the local rehabilitation fac record revealed a disc 10/8/20 that revealed Unspecified Intellectua Depressive Disorder, Hyperplasia, Schizoph Block, Presence of a of weakness, unsteading Further review of clien IPP since his admission	has, record review and ailed to ensure one newly ceived an individual thin 30 days after ag is: of client #2's record revealed e facility on 10/8/20 from a ility. Additional review of his charge summary dated client #2 had diagnoses of al disabilities, Major Benign Prostatic nrenia, Atrioventricular cardiac pacemaker, Muscle ess on feet and Dysphagia. ht #2's record revealed no on on 10/8/20.						
	DEFICIENCIES     CORRECTION     OVIDER OR SUPPLIER     RESIDENTIAL     SUMMARY STA     (EACH DEFICIENCY     REGULATORY OR L     Continued From page behavior inventory wa client #2's independer admitted to the facility Interview with the qua professional (QIDP) c for client #2 during the INDIVIDUAL PROGR.     CFR(s): 483.440(c)(4) Within 30 days after a interdisciplinary team client, an individual pr  This STANDARD is n Based on observatior interview, the facility fa admitted client (#2) re program plan (IPP) wi admission. The findin A. Review on 1/5/21 c he was admitted to the local rehabilitation fac record revealed a disc 10/8/20 that revealed Unspecified Intellectua Depressive Disorder, Hyperplasia, Schizopi Block, Presence of a c weakness, unsteading Further review of clier IPP since his admission	CORRECTION LIDENTIFICATION NUMBER: 34G257 OVIDER OR SUPPLIER	PEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A BUILD         34G257       B. WING         OVIDER OR SUPPLIER       34G257         RESIDENTIAL       IDENTIFICATION NUMBER:       ID         Continued From page 6       ID         Continued From page 6       W         behavior inventory was not completed to assess client #2's independent living skills after he was admitted to the facility on 10/8/20.       W         Interview with the qualified intellectual disabilities professional (QIDP) confirmed the lack of a CFA for client #2 during the exit conference on 1/6/21.       W         Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.       W         This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure one newly admitted client (#2) received an individual program plan (IPP) within 30 days after admission. The finding is:       A. Review on 1/5/21 of client #2's record revealed he was admitted to the facility on 10/8/20 from a local rehabilitation facility. Additional review of his record revealed a discharge summary dated 10/8/20 that revealed client #2 had diagnoses of Unspecified Intellectual disabilities, Major Depressive Disorder, Benign Prostatic Hyperplasia, Schizophrenia, Atrioventricular Block, Presence of a cardiac pacemaker, Muscle weakness, unsteadiness on feet and Dysphagia. Further review of client #2's record revealed no IPP since his admission on 10/8/20.	EPEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING         34G257       B. WING         OVIDER OR SUPPLIER       ID         RESIDENTIAL       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 6       W 224         behavior inventory was not completed to assess client #2's independent living skills after he was admitted to the facility on 10/8/20.       W 224         Interview with the qualified intellectual disabilities professional (QIDP) confirmed the lack of a CFA for client #2 during the exit conference on 1/6/21.       W 224         Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.       W 224         This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure one newly admitted client #2/2 received an individual program plan (IPP) within 30 days after admission. The finding is:       A. Review on 1/5/21 of client #2's record revealed he was admitted to the facility on 10/8/20 from a local rehabilitation facility. Additional review of his record revealed a discharge summary dated 10/8/20 that revealed client #2 had diagnoses of Unspecified Intellectual disabilities, Major Depressive Disorder, Benign Prostatic Hyperplasia, Schizophrenia, Atrioventricular Block, Presence of a cardiac pacemaker, Muscle weakness, unsteadiness on feet and Dysphagia. Further review of client #2's record revealed no IPP since his admission on 10/8/20.	EDEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         ABULDING	EPERCENCIES CORRECTION       (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BULDING BUILDING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE BHILLSIDE STREET CLARKTON, NC 28433         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST EE PRECEDED BY FULL RESULATORY OR LS DEPICIENCIES (EACH DEPICIENCY MUST EE PRECEDED BY FULL RESULATORY OR LS DEPICIENCIES (EACH DEPICIENCY MUST EE PRECEDED BY FULL RESULATORY OR LS DEPICIENCY RESULATORY OR LS DEPICIENCIES (EACH DEPICIENCY MUST EE PRECEDED BY FULL RESULATORY OR LS DEPICIENCY RESULATORY OR LS DEPICIENCIES (EACH DEPICIENCY)       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION RESULATORY OR LS DEPICIENCIES (EACH DEPICIENCY)         Continued From page 6       W 224         Continued From page 7       W 226         Cref(s): 483.440(c)(4)       W 226         Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.       W 226         This STANDARD is not met as evidenced by: Based on observations, record revealed to the readity on 10/8/20 from a local rehabilitation facility. Additional review of his record revealed a discharge summary dated 10/8/20 that revealed client #2 had diagnoses of Unspecified Intellectua	EPERFICIENCIES CORRECTION       (X1) PROVIDERSUPPLIERCUA DEMTRICATION NUMBER:       (X2) MULTIFIE CONSTRUCTION A BUILDING       (X3) DRAY A BUILDING         ONDER OR SUPPLIER       34G257       IN WING       (X3) DRAY BUILSIDE STREET       (X3) DRAY COMPARENT         CONDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE BE HILLSIDE STREET CLARKTON, NC 28433       (X4) COPERCINCES (EACH OPERCINC MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       ID PRETEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCINC MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         Continued From page 6 behavior inventory was not completed to assess client #25 independent living skills after he was admitted to the facility on 10/8/20.       W 224         Continued From page 6 behavior inventory was not conference on 1/6/21.       W 224         Continued From page 6 behavior inventory was not conference on 1/6/21.       W 226         INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)       W 226         Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.       W 226         This STANDARD Is not met as evidenced by: Based on observations, record revealed admitsed to the facility on 10/8/20 to may safter admission. The finding is: A. Review on 1/5/21 of client #2's record revealed a local rehabilitation facility. Additional review of his record revealed client #2's record revealed a local rehabilitation facility. Additional review of his record revealed client #2's record revealed a local rehabilitation facility. Additional revealed on ID/8/20 that

Facility ID: 922227

If continuation sheet Page 7 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/11/2021
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION		(X3) DATE COMP	LETED
		34G257	B. WING			_		C 06/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MIDLAKE	RESIDENTIAL				B HILLSIDE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 226	5:53pm for supper in the second stated in the has not had has he does a stated, " I stay in my revealed he has not had stated, " I stay in my revealed he has not had stated, " I stay in my revealed he has not had stated, " I stay in my revealed he has not had he has currently working on, Interview on 1/5/21 with the needs assistance with a thorough job. Additional the needs more medication administration and the needs more thas not had his IPP metals no formal objective Interview on 1/6/21 with an the qualified intell professional (QIDP) respondent	eption of coming out at the dining room. th client #2 at 5:11pm ad his IPP meeting. When II day at the facility, he oom and watch my TV". any programs that he is he stated, "No." th staff A revealed client #2 bathing to ensure he does onal interview revealed nt in dressing but needs asonally appropriate clothing nitoring in toothbrushing, tion and other areas in interview revealed client #2 objectives, "Because, he ng yet." th staff C revealed client #2 eeting and that he currently res that he is working on. th the program manager ectual disabilities evealed client #2 has not ince his admission on o formal objectives. AM PLAN ((iii) m plan must include, for t them, training in personal acy and independence ted to, toilet training,						
		ted to, toilet training, tal hygiene, self-feeding,						

Facility ID: 922227

If continuation sheet Page 8 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/11/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		34G257	B. WING		-	01/	C 06/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MIDLAKE	RESIDENTIAL			8 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 242	of basic needs), until that the client is deve acquiring them.	e 8 oming, and communication it has been demonstrated opmentally incapable of not met as evidenced by:	W 242				
	Based on observation review, the facility fail individual program pla address his basic skil bathing, toileting, dres	ns, interviews and record ed to ensure client #2's an (IPP) included training to I needs which included ssing, toothbrushing and is affected 1 of 3 audit					
	from 3:30pm-6:45pm	ons in the facility on 1/5/21 client #2 remained in his eption of coming out at the dining room.					
	client #2 stayed in his television. The progra checked him at 15 mi get up and get dresse came to the medication medication packets for put in applesauce and applesauce with a spe independently poured his trash. At 7:31am, room for breakfast in of precut toast, scram consumed his breakfast being monitored by di beside him. Review on 1/5/21 of c	Im manager, Staff C and D nute intervals to ask him to ed. At 7:19am, client #2 on room, staff opened the or him. His medications were d he scooped the bon. Client #2 I his water and disposed of client #2 came to the dining his pajamas. He had a plate bled eggs and grits. He ast without difficulty while rect care staff C sitting					
	he was admitted to th	e facility on 10/8/20 from a					

If continuation sheet Page 9 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/11/2021 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		34G257	B. WING		-		C 06/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	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-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 242	adaptive behavior inv independence in bath communication, groon administration or mea Interview with staff A n assistance with bathin thorough job. Addition #2 is independent in or reminders to wear sea and that he needs mor medication administra grooming. Interview on 1/6/21 w medication technician requires assistance w administration. Interview on 1/6/21 w and the program man behavior inventory to independence in bath communication, groon	<ul> <li>cility.</li> <li>/20 revealed there was no entory to assess client #2's ing, dressing, toileting, ming, medication and preparation.</li> <li>revealed client #2 needs the does a the interview revealed client dressing but needs asonally appropriate clothing onitoring in toothbrushing, the staff D, who was the and the rareas in</li> <li>ith staff D, who was the and the life skills specialist ager revealed an adaptive assess client #2's ing, dressing, toileting, totleting, t</li></ul>	W 242				
W 249	disabilities profession client #2 had not been training in the areas of grooming, dressing, n medication administra	neal preparation and ation. ENTATION	W 249				

If continuation sheet Page 10 of 21

		ID HUMAN SERVICES				FOR	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		34G257	B. WING				/06/2021
NAME OF P	ROVIDER OR SUPPLIER	I		Ś	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 249	Continued From page	e 10	w	249			
	each client must rece treatment program co interventions and ser and frequency to sup	ndividual program plan, ive a continuous active					
	Based on observatio interviews, the facility clients (#2 and #5) re treatment program co interventions and ser development of an in- for client #2 after adm	not met as evidenced by: ns, record reviews and failed to ensure 2 of 3 audit ceived a continuous active onsisting of needed vices by failing to ensure the dividual program plan (IPP) nission as well as failing to ent #5's feeding guidelines.					
		of client #2's record revealed le facility on 10/8/20 from a sility.					
	from 3:30pm-6:45pm	ions in the facility on 1/5/21 client #2 remained in his ception of coming out at the dining room.					
	client #2 stayed in his television. The progra checked him at 15 mi get up and get dresse came to the medication	ions in the facility on 1/6/21 s bedroom watching am manager, Staff C and D inute intervals to ask him to ed. At 7:19am, client #2 on room, staff opened the or him. His medications were					

Facility ID: 922227

If continuation sheet Page 11 of 21

PRINTED: 01/11/2021

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	): 01/11/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G257	B. WING		_	01/0	C 06/2021
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 / 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 249	his trash. At 7:31am, room for breakfast in of precut toast, scram consumed his breakfa being monitored by di beside him. Interview on 1/5/21 w revealed he has not h asked what he does a stated, "I stay in my ro When asked if he has currently working on, Interview on 1/5/21 w needs assistance with a thorough job. Additi client #2 is independer reminders to wear sea and that he needs mo medication administra grooming. Continued has no current formal has not had his meeti Interview on 1/6/21 w has not had his IPP m has no formal objectiv Interview on 1/6/21 w and the qualified intel professional (QIDP) m had an IPP meeting s 10/8/20.	A he scooped the bon. Client #2 his water and disposed of client #2 came to the dining his pajamas. He had a plate bled eggs and grits. He ast without difficulty while rect care staff C sitting th client #2 at 5:11pm ad his IPP meeting. When all day at the facility, he bom and watch my TV". any programs that he is he stated, "No." th staff A revealed client #2 h bathing to ensure he does bonal interview revealed ont in dressing but needs asonally appropriate clothing mitoring in toothbrushing, ation and other areas in interview revealed client #2 objectives, "Because, he ng yet." th staff C revealed client #2 objectives, "Because, he ng yet."	W 249				

If continuation sheet Page 12 of 21

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	): 01/11/2021 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		SURVEY LETED
		34G257	B. WING			-	( 01/	) 06/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MIDLAKE	RESIDENTIAL				B HILLSIDE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 249	#5 was seated at the sided sectioned plate. consistency which inclutater tots, fruit cocktail sat next to her during over her plate and scorrepeatedly. Staff G verpace of eating. Twice cued to stop and sip h during the meal, was coughed several time. During observations of 7:35am client #5 was with a high sided, sec cups. Staff F served p pureed toast and grits she began to lean over her spoon and into her beside her at the meal her food onto her spou up put her utensil dow meal. She coughed set meal. Review on 1/5/21 of crevealed eating guide indicated the following 1) Take mouthful of for 2) Chew food complet 3) hold head up 4) sip liquids 5) wipes mouth with a linterview on 1/6/21 widisabilities profession.	kitchen ledge with a high Her supper was pureed luded a hamburger, bun, I, water and koolaid Staff G the meal. Client #5 leaned boped food into her mouth arbally cued her to slow her during the meal, she was her beverages. At no time she cued to sit up. She is during her meal. If breakfast on 1/6/21 at seated at the kitchen ledge tioned plate, utensils and bureed scrambled eggs, is onto her plate. At 7:40am er her plate, scoop food onto er mouth. Staff F was seated II. She repeatedly scooped on. She was not cued to sit <i>u</i> at any time during the everal times during her lient #5's IPP dated 9/22/20 lines dated 10/2/17 which g; od tely assistance ith the qualified intellectual al (QIDP) revealed these still current and should be	W	249				

Facility ID: 922227

If continuation sheet Page 13 of 21

		MEDICAID SERVICES				<u>0. 0938-039</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED	
			A. BUILDING			С	
		34G257	B. WING		01/06/2021		
NAME OF P	ROVIDER OR SUPPLIER		s	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 254	Continued From page	e 13	W 254				
W 254		ENTATION	W 254				
	contribute to an over	ument significant events that all understanding of the and quality of functioning.					
	Based on record rev qualified intellectual o (QIDP) failed to revie	not met as evidenced by: iew and interview the disabilities professional w the written training udit clients (#1 and #5). The					
	9/22/20 revealed she programs which inclu for 3 minutes for 20/3 dining room table at a 20 consecutive days, hands once daily for improve grooming sk toothbrushing in her days and participating	ded: attending to an activity do days, correctly setting the evening meals once daily for Participating in washing her 30/30 consecutive days, ills by tolerating mouth for 30 consecutive g in a sensory stimulation 30 consecutive days. These					
	program plan (IPP) d had formal training ol participating in exerci	of client #1's individual ated 2/24/20 revealed she ojectives which included: ising once daily for 30 prove grooming skills by					

Facility ID: 922227

If continuation sheet Page 14 of 21

						FORM	01/11/2021 APPROVED
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		OMB NO. 093 (X3) DATE SURVE COMPLETED		
		34G257	B. WING		_	( 01/	C 06/2021
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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 254	independently brushir consecutive days, Par once daily for 30 cons her hair three times w bedroom floor for 30 c Review on 1/6/21 of th in December revealed currently being trained Review on 1/6/21 of th these programs revea notation of progress of programs implemental Interview on 1/6/21 wi disabilities profession not reviewed client #1 objectives since their months). PROGRAM MONITOD CFR(s): 483.440(f)(3) The committee should monitor individual pro- inappropriate behavio in the opinion of the c client protection and r Based on record revi failed to ensure the re- techniques which incli-	ng her teeth for 20 rticipate in washing her face secutive days, shampooing reekly and sweeping her consecutive days. The data for these programs d these programs were d. The progress summaries for aled there had been no or lack of progress since the tion on 3/2/2020. The qualified intellectual al (QIDP) revealed she had 's progress on these implementation on 3/2/20 (9 RING & CHANGE (i) d review, approve, and grams designed to manage or and other programs that, ommittee, involve risks to ights.	W 24	54			

Facility ID: 922227

If continuation sheet Page 15 of 21

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 01/11/2021
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		34G257	B. WING _	B. WING				C 06/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MIDLAKE RESIDENTIAL					3 HILLSIDE STREET LARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 262 W 263	Review on 1/5/21 of c he was admitted to the local rehabilitation factor Review on 1//5/21 of c dated 11/1/20 reveale Zyprexa, Zoloft, Coge address his behaviora Further review on 1/6/21 with consent by the human the use of these psych Interview on 1/6/21 with disabilities profession of these psychotropic approved by the HRC to the facility on 10/8/2 PROGRAM MONITOR CFR(s): 483.440(f)(3) The committee should are conducted only with consent of the client, f minor) or legal guardia This STANDARD is m Based on record revit failed to ensure writte obtained from client # psychotropic medicatia audit clients (#2). The Review on 1/5/21 of c	lient #2 's record revealed e facility on 10/8/20 from a ility. client #2's physician orders d client #2 receives intin and Trazedone to al needs. /21 revealed no review or n rights committee (HRC) for hotropic medications. /21 revealed no review or n rights committee (HRC) for hotropic medications. /21 revealed no review or n rights committee (HRC) for hotropic medications. /21 revealed no review or n rights committee (HRC) for hotropic medications. //21 revealed intellectual al (QIDP) revealed the use medications had not been since client #2's admission 20. RING & CHANGE (ii) d insure that these programs ith the written informed parents (if the client is a an. //// events a evidenced by: ew and interview, the facility n informed consent was 2's guardian for the use of ons. This affected 1 of 3 e finding is: lient #2's record revealed e facility on 10/8/20 from a	W 2					

Facility ID: 922227

If continuation sheet Page 16 of 21

		D HUMAN SERVICES					FORM	01/11/2021
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	LETED
		34G257	B. WING _			_	01/	C 06/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MIDLAKE RESIDENTIAL					HILLSIDE STREET LARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 263 W 312	dated 11/1/20 revealed Zyprexa, Zoloft, Coge address his behaviora Review on 1/5/21 of o he had been adjudica Guardian appointed to Review on 1/5/21 of o no written informed co guardian for the use of Interview on 1/6/21 w skills specialist reveal written informed cons psychotropic medicati Interview on 1/6/21 w disabilities profession was not written inform client #2's psychotrop DRUG USAGE CFR(s): 483.450(e)(2 Drugs used for controp must be used only as client's individual prog specifically towards th elimination of the beh are employed.	<ul> <li>dient #2's physician orders of client #2 receives entin and Trazedone to al needs.</li> <li>dient #2's record revealed ted and had a General point of a context on his behalf.</li> <li>dient #2's record revealed ted and had a General point from client #2's of psychotropic medications.</li> <li>dient #2's record revealed the facility nurse and life ed they could not locate ent for the use of client #2's fors.</li> <li>dient the qualified intellectual al (QIDP) revealed there hed consent for the use of client #2's fors.</li> <li>d) of inappropriate behavior an integral part of the gram plan that is directed here reduction of and eventual aviors for which the drugs</li> </ul>	W :	312				
	This STANDARD is r Based on record revi facility failed to ensure #2's behavior were or	ew and interviews, the						

If continuation sheet Page 17 of 21

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/11/2021 APPROVED . 0938-0391
STATEMENT O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G257	B. WING				) )6/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MIDLAKE RESIDENTIAL			-	8 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 312		: 17 lients (#2) The finding is: lient #2 's record revealed	W 312				
	local rehabilitation fac Review on 1//5/21 of	client #2's physician orders					
	address his behaviora	ntin and Trazedone to al needs.					
	revealed no behavior be used in conjunction	/21 of client #2's record support program (BSP) to n with the psychotropic rescribed by his physician.					
	Interview on 1/5/21 w revealed client #2 doe	th the program manager as not have a BSP.					
W 340	disabilities profession		W 340				
	other members of the appropriate protective measures that include	t include implementing with interdisciplinary team, and preventive health b, but are not limited to aff as needed in appropriate ethods.					
	Based on observation	not met as evidenced by: ns, record review and staff failed to ensure competency prevent cross					

Facility ID: 922227

If continuation sheet Page 18 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/11/2021 APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SUF COMPLET		
		34G257	B. WING _			_	( 01/	C 06/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
MIDLAKE	RESIDENTIAL				HILLSIDE STREET LARKTON, NC 28433				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 340	<ul> <li>clients (#1, #2, #3, #4 maintain the proper fit interacting with all the findings are:</li> <li>A. During observation 3:49pm direct care sta clocked in and started kitchen not wearing a manager stopped her administration to ask a mask.</li> <li>B. During observation into work wearing his He administered med 7:27am wearing his fai intervals.</li> <li>C. During observation finish their meal to con administration. His fac nose.</li> <li>Review on 1/5/21 and material by the facility throughout the facility to wear masks in the facility to wear masks in the facility to wear masks in the facility. Information in described how the main nose and mouth at all Interview on 1/6/21 without and the facility information in</li> </ul>	providing services to 5 of 5 and #5) as well as failed to a of face masks while clients in the home. The s in the facility on 1/5/21 at aff C came into the facility , l assisting clients in the face mask. The program preparation of medication staff C to put on a face s on 1/6/21 staff D clocked face mask below his nose. ications to client #1 at ace mask below his chin at as on 1/6/21 at 7:48 am staff room waiting for clients to ntinue medication ce mask was worn below his con the front door and reminded direct care staff facility to protect the clients. in inservice dated 11/10/20 ie COVID-19 Pandemic and a wearing a mask in the	W 3	40					

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>			C	FORM APPROV OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	591
34G257	B. WING		_	C 01/06/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MIDLAKE RESIDENTIAL		68 HILLSIDE STREET CLARKTON, NC 28433			
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		ON
<ul> <li>W 340 Continued From page 19 been inserviced about the importance of wearing a mask in the facility due to the current COVID-19 pandemic. The registered nurse emphasized it is imperative that masks worn by all staff must be worn over the nose and mouth to be effective. However as evidenced by observations of staff additional training needs to be completed.</li> <li>W 369 DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</li> <li>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</li> <li>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility's system for drug administration failed to assure all drugs were administered without error for 1 of 4 clients observed during drug administration (#1). The finding is:</li> <li>During observations of medication administration on 1/6/21 at 7:27am client #1 received Levothyroxine 75 MCG (1), Lithium Carbonate 300 mg. (1), Doxycycline 100mg. (1), and Vitamin D3 (1).</li> <li>Immediate interview with the staff D who was the medication technician revealed client #1 was out of her birth control medication Jolessa 0.15 mg. Staff D stated that the pharmacy had been notified and that client #1 had not received this medication as ordered since 1/4/21.</li> <li>Review on 1/6/21 of client #1 physician's orders dated 11/10/21 revealed a order for client #2</li> </ul>	W 36				

Facility ID: 922227

If continuation sheet Page 20 of 21

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/11/2021 APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G257	B. WING					C 06/2021	
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STAT	E, 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 PREF TAG		(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
W 369	"Jolessa 0.16.mg/0.03 mouth daily." Interview on 1/6/21 w client #1's Jolessa wa had been ordered by	e 20 3mg Take (1) tablet by ith the facility nurse revealed as out of stock and that it the pharmacy, however she 1/4/21, 1/5/21 and 1/6/21.	W	369					

Event ID: Y9QN11

Facility ID: 922227

If continuation sheet Page 21 of 21