		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		34G257	B. WING			04/0	09/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKI	E RESIDENTIAL				669 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
PRÉFIX TAG	REGULATORY OR L EP Training Progra CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §44 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, OI RHC/FQHCs at §48 (1) Training progra the following: (i) Initial training in o policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emerge least every 2 years. (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergence procedures are sign must conduct traini procedures.	SC IDENTIFYING INFORMATION) m (1) 16.54(d)(1), §418.113(d)(1), 50.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 35.920(d)(1), §486.360(d)(1), 03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at entation of all emergency			CROSS-REFERENCED TO THE APPROP		
	hospice must do all (i) Initial training in o policies and proced hospice employees						

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 04/10/2024

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.

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		34G257	B. WING _		04	/09/2024	
	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 369 E GREEN STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETIO DATE	
E 037	procedures. (iii) Provide emerge least every 2 years. (iv) Periodically revi emergency prepare employees (includir special emphasis p procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergence procedures are sign must conduct traini procedures are sign must conduct traini procedures. *[For PRTFs at §44 program. The PRTI (i) Initial training in o policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial traini preparedness traini (iii) Demonstrate sta procedures. (iv) Maintain docum preparedness traini (v) If the emergence procedures are sign must conduct traini procedures. *[For PACE at §460 organization must of	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. by preparedness policies and hificantly updated, the hospice ng on the updated policies and enter the following: emergency preparedness lures to all of the following: emergency preparedness lures to all new and existing by ding services under volunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	EO	37			

Facility ID: 922227

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING			04/0	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL				369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includin what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct trainin procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all o (i) Provide initial tra preparedness polici and existing staff, in	Jures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ing informing participants of o go, and whom to contact in ncy. The tation of all training. By preparedness policies and hificantly updated, the PACE ing on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their incy preparedness training at the tation of all emergency ing. aff knowledge of emergency as and procedures to all new individuals providing services , and volunteers, consistent	EC	037			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING	i		04/(	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL				369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 037	<ul> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum (iv) Demonstrate stap procedures. All new and assigned speci the CORF's emerger their first workday.</li> <li>include instruction in alarm systems and equipment.</li> <li>(v) If the emergen procedures are sign must conduct training procedures.</li> <li>*[For CAHs at §485 The CAH must do at (i) Initial training in e policies and proced reporting and exting and where necessan personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, corr roles.</li> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum (iv) Demonstrate stap procedures.</li> <li>(v) If the emergen procedures are sign</li> </ul>	ncy preparedness training at nentation of the training. aff knowledge of emergency w personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting cy preparedness policies and hificantly updated, the CORF ng on the updated policies and 5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at	E	037			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM /	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		34G257	B. WING		04/0	9/2024
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL			369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	*[For CMHCs at §44 CMHC must provide preparedness polici and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on documer facility failed to ensu- adequately trained of preparedness (EP) Review on 4/8/24 or (3/14/24) did not indo- regarding training of During an interview Care Facility Region confirmed there we the EP concerning the EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §418 §485.542(d)(2), §48 §485.542(d)(2), §48 §485.542, OPO, §485.727, CMHCs	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services , and volunteers, consistent roles, and maintain ne training. The CMHC must nowledge of emergency after, the CMHC must provide edness training at least every 2 s not met as evidenced by: nt review and interviews, the ure direct care staff were on the facility's emergency plan. The finding is: f the facility's EP manual clude any information f staff. on 4/9/24, the Intermediate nal Director (ICFRD) re no information included in training of the staff. ments	E 03	7		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING			04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE	ERESIDENTIAL				69 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 5	EC	39			
	<ul> <li>(2) Testing. The [fact to test the emergen must do all of the foct to test the emergen must do all of the foct to test the emergen must do all of the foct (i) Participate in a full community-based et (A) When a community-based et (A) When a community-based et (B) If the [facilit natural or man-mace activation of the emerger exempt from engage community-based of functional exercise actual event.</li> <li>(ii) Conduct an addit years, opposite the functional exercise this section is conduct in the follow of (A) A second full-section functional exercise;</li> <li>(B) A mock disaster (C) A tabletop exercise a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [face maintain document]</li> </ul>	cility] must conduct exercises cy plan annually. The [facility] illowing: ull-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ars; or y] experiences an actual le emergency that requires ergency plan, the [facility] is ing in its next required or individual, facility-based following the onset of the tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is lowing: ale exercise that is or individual, facility-based or drill; or cise or workshop that is led by udes a group discussion using <i>x</i> -relevant emergency of problem statements, or prepared questions ge an emergency plan. ility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.					
	*[For Hospices at 4	18.113(d):]					

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING	i		04/(	09/2024
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL				369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based et (A) When a communate community based et (A) When a communate community based et (A) When a communate emerge (B) If the hospice examples the emergency plarengaging in its next community-based function on the emergency plarengaging in its next community-based functions of the emerge (ii) Conduct an add opposite the year the exercise under parais conducted, that not to the following:</li> <li>(A) A second full-sec community-based of exercise; or</li> <li>(B) A mock disaster (C) A tabletop exert a facilitator and incla narrated, clinically scenario, and a set directed messages, designed to challen</li> <li>(3) Testing for hosp care directly. The hexercise to test the year. The hospice</li> </ul>	pices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section nay include, but is not limited cale exercise that is or a facility based functional er drill; or rcise or workshop that is led by ludes a group discussion using y-relevant emergency of problem statements, , or prepared questions age an emergency plan.		039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G257	B. WING			04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL			-	69 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	<ul> <li>(A) When a commutation accessible, conduct facility-based function (B) If the hospice examples of the emergency plane engaging in its next based or facility-based following the onset of (ii) Conduct an add may include, but is (A) A second full-secommunity-based of exercise; or</li> <li>(B) A mock disaster (C) A tabletop exert facilitator that include narrated, clinically-rand a set of problem messages, or preparent challenge an emerge (iii) Analyze the host maintain documentate exercises, and emerge hospice's emergence</li> <li>*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises to twice per year. The do the following: (i) Participate in an is community-based of (A) When a commutate community-based of the community-based (A) When a commutate (A) When (A) When</li></ul>	<ul> <li>inity-based exercise is not it an annual individual onal exercise; or experiences a natural or ncy that requires activation of n, the hospice is exempt from required full-scale community sed functional exercise of the emergency event.</li> <li>litional annual exercise that not limited to the following: cale exercise that is or a facility based functional</li> <li>er drill; or cise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan.</li> <li>spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.</li> <li>1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must</li> <li>annual full-scale exercise that d; or unity-based exercise is not t an annual individual,</li> </ul>	E	039			

Facility ID: 922227

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	-	AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G257	B. WING			04/0	09/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E RESIDENTIAL				69 E GREEN STREET LARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may include following:</li> <li>(A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop of led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents exercises, and eme [facility's] emergency</li> <li>*[For PACE at §460 (2) Testing. The PA exercises to test the annually. The PACE following:</li> <li>(i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp</li> </ul>	<ul> <li>bispital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event.</li> <li>[additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency</li> <li>[facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.</li> <li>0.84(d):]</li> <li>CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise is not t an annual individual,</li> </ul>		39			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
l		34G257	B. WING	;		04/(	09/2024
NAME OF I	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL				369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the y exercise under para is conducted that m the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster (C) A tabletop exer a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu	a, the PACE is exempt from a required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based or er drill; or rcise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. .CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):] of must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual,	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		34G257	B. WING	i		04/(	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MIDLAKE	E RESIDENTIAL				869 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	requires activation of LTC facility is exem required a full-scale individual, facility-ba following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emerge [LTC facility] facility' *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must de (i) Participate in an is community-based (B) If the ICF/IID ex man-made emerge the emergency plar engaging in its next community-based of	of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or cise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises to plan at least twice per year. o the following: annual full-scale exercise is not t an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G257	B. WING			04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	ERESIDENTIAL				69 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	<ul> <li>(ii) Conduct an addi may include, but is</li> <li>(A) A second full-sc community-based of functional exercise;</li> <li>(B) A mock disaster</li> <li>(C) A tabletop exerce</li> <li>a facilitator and inclusing a narrated, clusing a narrate</li></ul>	tional annual exercise that not limited to the following: ale exercise that is or an individual, facility-based or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. /IID's response to and ation of all drills, tabletop ergency events, and revise the y plan, as needed. 102] HHA must conduct exercises cy plan at HHA must do the following: ull-scale exercise that is or nmunity-based exercise is not t an annual individual, onal exercise an actual natural gency that requires activation lan, the HHA is exempt from	EC	039			

Facility ID: 922227

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		AND HUMAN SERVICES				FORM	: 04/10/2024 APPROVED . 0938-0391			
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		34G257	B. WING	i		04/	09/2024			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•				
MIDLAKI	E RESIDENTIAL		369 E GREEN STREET CLARKTON, NC 28433							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE			
E 039	limited to the followi (A) A second fu community-based of functional exercise; (B) A mock disa (C) A tabletop e led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HH, documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergen following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. If the OPO ex man-made emergen the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a	ring: III-scale exercise that is or an individual, facility-based ; or aster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant to, and a set of problem ad messages, or prepared d to challenge an emergency IA's response to and maintain III drills, tabletop exercises, and and revise the HHA's is needed. 6.360] OPO must conduct exercises ney plan. The OPO must do the r-based, tabletop exercise or annually. A tabletop exercise is and includes a group narrated, clinically relevant to, and a set of problem ad messages, or prepared to challenge an emergency periences an actual natural or ency that requires activation of n, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain III tabletop exercises, and and revise the [RNHCI's and	EC	039						

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G257	B. WING			04/0	09/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAK	E RESIDENTIAL			-	369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039 W 111	*[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followir (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency eve emergency plan, as This STANDARD is Based on document facility failed to ensi- mock drill or an any conducted and inclu- Emergency Prepare is: Review on 4/8/24 th annual tabletop, full being completed. During an interview Facility Regional Di facility's EP Plan did detailing any exerci CLIENT RECORDS CFR(s): 483.410(c)	748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at obetop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's is needed. Is not met as evidenced by: int review and interviews, the ure a full scale exercises, hual tabletop activity was uded in the facility's edness Plan (EP). The finding here was no evidence of a I scale exercise or mock drill fon 4/9/24, Intermediate Care rector (ICFRD) confirmed the d not have documentation ses to test their EP plan. (1) evelop and maintain a em that documents the client's treatment, social information,	E C	111			

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		AND HUMAN SERVICES			FORM	04/10/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G257	B. WING _		04/09/2024	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MIDLAKE RESIDENTIAL				369 E GREEN STREET CLARKTON, NC 28433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 111 W 210	This STANDARD is Based on observat interviews, the facili diet order information The finding is: Review on 4/8/24 of located in the home was not listed. During an interview client #6's name was information sheet. During an interview Manager (PM) rever client #6's name was information sheet. During an interview Care Facility Region the diet order inform update, due to the f included. INDIVIDUAL PROC CFR(s): 483.440(c) Within 30 days after interdisciplinary teal assessments or real supplement the pre- prior to admission. This STANDARD is Based on record re- failed to obtain an in	s not met as evidenced by: tions, record reviews and ity failed to maintain current on for 1 of 4 audit clients (#6). f client order information e revealed client #6's name on 4/8/24, Staff A confirmed as not listed on the diet f on 4/8/24, the Program ealed he was not sure why as not listed on the diet f on 4/9/24, the Intermediate nal Director (ICFRD) stated nation sheet needs to be fact client #6's name is not GRAM PLAN (3)	W 1 W 2			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G257 B. WING 04/09/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **369 E GREEN STREET** MIDLAKE RESIDENTIAL CLARKTON, NC 28433 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 210 Continued From page 15 W 210 Review on 4/8/24 of client #6's record revealed she had not received a Psychological Evaluation. Further review revealed client #6 was admitted to the facility on 2/6/24. During an interview on 2/6/24, the Intermediate Care Facility Regional Director (ICFRD) confirmed client #6 had not received her Psychological Evaluation. W 248 INDIVIDUAL PROGRAM PLAN W 248 CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure current Individual Program Plan (IPP) were available to all relevant staff. This affected 1 of 4 audit client (#6). The finding is: Record review on 4/8/24 of client #6's record revealed she was admitted to the home on 2/6/24. Further review revealed relevant staff did not have access to clients #6's IPP. During an interview in 4/9/24, the Intermediate Care Facility Regional Director (ICFRD) confirmed client #6 did not have a IPP within 30 days of their admission to the facility. Further interview revealed the Qualified Intellectual Disabilities Professional (QIDP) is responsible to ensure IPP's are completed for newly admitted clients. W 263 PROGRAM MONITORING & CHANGE W 263

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	04/10/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G257	B. WING				04/09/2024	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDF	RESS, CITY, STATE	E, ZIP CODE	-	
MIDLAKI	E RESIDENTIAL			369 E GREEI CLARKTON	N STREET I, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAG	ROVIDER'S PLAN ( CH CORRECTIVE A S-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
W 263	Continued From pa CFR(s): 483.440(f)(	-	W 20	33				
W 368	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re- failed to ensure res- conducted with the legal guardian. This (#4). The finding is Review on 4/8/24 or Plan (BSP) implement was no signed conse During an interview Care Facility Region confirmed client #4 consent by his lega DRUG ADMINISTR CFR(s): 483.460(k)	s not met as evidenced by: eview and interview, the facility trictive programs were only written informed consent of a s affected 1 of 4 audit clients : f client #4's Behavior Support ented 2/2023 revealed there sent by his legal guardian. on 4/9/24, the Intermediate hal Director (ICFRD) does not have a signed I guardian. ATION (1) g administration must assure	W 3	58				
	the physician's order This STANDARD is Based on observat interviews, the facili medications were a with physician's ord clients (#2). The fir During morning me home on 6/22/22 at nineteen pills and n	s not met as evidenced by: ions, record reviews and ty failed to ensure dministered in compliance ers. This affected 1 of 4 audit						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G257 B. WING 04/09/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **369 E GREEN STREET** MIDLAKE RESIDENTIAL CLARKTON, NC 28433 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 368 Continued From page 17 W 368 any other medications. Additional observations revealed the surveyor entered the home at 6:53am and client #2 was up and dressed. Review on 4/9/24 of client #2's physician orders (signed 2/21/24) revealed client #2 should have received Artificial Tears (two drops in each eye), Nyamyc and Vicks Vapor rub between his toes at 8am. During an interview on 4/9/24, the facility's nurse confirmed client #2 should have received Artificial Tears, Nyamyc and Vicks Vapor rub at 8am. W 369 DRUG ADMINISTRATION W 369 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 staff interviews, the facility failed to ensure medications were administered without error for 1 of 4 clients (#2) observed during the administration of medications. The finding is: During medication administration observations in the home on 4/9/24 at 8:05am, client #2 received one spray of his nose spray in each nostril. Review on 4/9/24 of client #2's physician orders (signed 2/21/24) revealed client #2 is to get two sprays in each nostril of his nose spray. During an interview on 4/9/24, the facility's nurse confirmed client #2 should get two sprays of his nose spray in each nostril. **EVACUATION DRILLS** W 440 W 440

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G257	B. WING			04/09/2024		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MIDLAKE RESIDENTIAL					69 E GREEN STREET LARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 440	Continued From pa CFR(s): 483.470(i)(	0	W 4	40				
	This STANDARD is Based on review of interviews, the facili evacuation drills we This potentially affe	r each shift of personnel. s not met as evidenced by: f fire drill reports and ty failed to ensure fire ere conducted at varied times. cted all clients (#1, #2, #3, #4, in the home. The finding is:						
	revealed there when November, Decemb Further review reve documented for Aug 2023. Additional re	f the facility's fire drills re no fire drills conducted in per 2023 and January 2024. aled there were no times gust, September and October view revealed there were only rills conducted on 6/3/23 and e).						
	Manager (PM) conf	on 4/8/24, the Program irmed the times for the fire August, September and hissing.						
W 473	Care Facility Region confirmed fire drills documented correc	-	W 4	73				
	This STANDARD is Based on observat failed to ensure food appropriate tempera	ed at appropriate temperature. s not met as evidenced by: ions and interviews, the facility d was served at the ature. This potentially affected ne (#2, #3, #4, #5 and #6)						

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		AND HUMAN SERVICES				FORM	: 04/10/2024 APPROVED . 0938-0391	
STATEMENT	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
	34G257		B. WING	;		04/09/2024		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MIDLAKE RESIDENTIAL					369 E GREEN STREET CLARKTON, NC 28433			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 473	Continued From pa	ige 19	W 4	473	3			
	at 5:22pm, yams we 5:23pm peas and c serving dish and at placed in a serving revealed client #6 b followed by the othe time were any of he them eating. During an interview what temperature h Further interview re how long hot food c be reheated. When show the surveyor a thermometer. During an interview what temperature h did not know how lo needs to be reheated During an interview Care Facility Region know what temperation served at. Addition	on 4/8/24, Staff B did not now not food should be at. Staff B ong food can sit out before it ed. on 4/9/24, the Intermediate nal Director (ICFRD) did not ature hot food should be nal interview revealed the w how long food can sit out						

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