

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

PRINTED: 07/07/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/03/2024
NAME OF PROVIDER OR SUPPLIER MIDLAKE RESIDENTIAL			STREET ADDRESS, CITY, STATE, ZIP CODE 369 E GREEN 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 000	INITIAL COMMENTS	W 000			
{W 263}	<p>A revisit was conducted on 7/3/24 for all previous deficiencies cited on 4/9/24. All deficiencies were not corrected and no new non-compliance was found. The facility is not in compliance with all regulations surveyed.</p> <p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#4). The finding is:</p> <p>Review on 4/8/24 of client #4's Behavior Support Plan (BSP) implemented 2/2023 revealed there was no signed consent by his legal guardian.</p> <p>During an interview on 4/9/24, the Intermediate Care Facility Regional Director (ICFRD) confirmed client #4 does not have a signed consent by his legal guardian.</p> <p>A follow up visit was conducted on 7/2/24:</p> <p>During an interview the QIDP revealed client #4 still does not have a legal guardian.</p>	{W 263}			

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

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.