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

PRINTED: 01/11/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G317	B. WING _			R 08/2021	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 5927 LAKEVIEW DRIVE CHARLOTTE, NC 28270	, on	00/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W 227}	objectives necessary as identified by the corequired by paragraph. This STANDARD is repaired by paragraph. This STAND	m plan states the specific to meet the client's needs, imprehensive assessment in (c)(3) of this section. not met as evidenced by: ns, record review, and -centered plan (PCP) failed aining objectives or to behavior management for s (#4). The finding is: roup home on 10/13/20 PM revealed client #4 to activities including a game dication administration, partation and to participate bservations at 5:35 PM stand in his bedroom with no brief in his hands while were going in and out of acent to his room. Further at client #4 was without pants and visible from the hallway. The stand in the doorway and to sing the door behind her. The sat 6:15 PM revealed of his room with a clean to choose a game activity for client #4 revealed a (PCP) dated 2/28/20 which	{W 22				
ABORATORY		program goals: request 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.

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		34G317	B. WING_			R 01/08/2021	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{W 227}	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{W 22	27)			

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{W 227}	Continued From page submitted.	2	{W 227	7}		