

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: 34G317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/08/2021
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKEVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 5927 LAKEVIEW DRIVE CHARLOTTE, NC 28270
-----------------------------------------------------	---------------------------------------------------------------------------------------------

(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 227}	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review, and interviews the person-centered plan (PCP) failed to include sufficient training objectives or interventions relative to behavior management for 1 of 3 sampled clients (#4). The finding is:</p> <p>Observations in the group home on 10/13/20 from 4:00 PM to 6:00 PM revealed client #4 to participate in various activities including a game activity with staff, medication administration, assist with dinner preparation and to participate in the dinner meal. Observations at 5:35 PM revealed client #4 to stand in his bedroom with no pants on and an adult brief in his hands while other clients and staff were going in and out of the laundry room adjacent to his room. Further observations revealed client #4 was without pants and undergarments and visible from the hallway. Further observations at 5:40 PM revealed staff A to witness client #4 to stand in the doorway and to rush into his room closing the door behind her. Continued observations at 6:15 PM revealed client #4 to come out of his room with a clean t-shirt and shorts and to choose a game activity with staff assistance.</p> <p>Review of the record for client #4 revealed a person centered plan (PCP) dated 2/28/20 which includes the following program goals: request</p>	{W 227}	<p>W227</p> <p>The Qualified Professional (QP) will hold a Team Meeting to discuss Client #4's inappropriate toileting. The Habilitation Specialist will in-service the direct care staff on the results of the team meeting. The QP will revise the Person Centered Plan for Client #4 to reflect the results of the Team Meeting. The clinical team will monitor through Interaction Assessments twice per week for one month and then on a routine basis to ensure Client #4's inappropriate toileting needs are being addressed. Going forward, the QP will ensure the Person Centered Plan includes sufficient training objectives or interventions relative to behavior management.</p> <p>DHSP - Mental Health JAN 28 2021 Lic. & Cert. Se 1/11</p>	2/8/2021
---------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director of Operations	(X6) DATE 1/14/2021
--------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------

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.

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: 34G317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/08/2021
NAME OF PROVIDER OR SUPPLIER LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 5927 LAKEVIEW DRIVE CHARLOTTE, NC 28270		
(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 227}	<p>Continued From page 1</p> <p>that staff participate in an activity with him, exhibit less than 35 incidents of target behaviors for six months, use picture symbols, participate in community outings, work a puzzle, and use proper etiquette during meals. Further review of the record did not include training objectives or interventions relative to inappropriate toileting. Review of the behavior support plan (BSP) dated 10/15/19 states that client #4 exhibits the following target behaviors: kicks walls, doors, self-injurious behaviors, (SIBs), and physical aggression towards staff. Further review of the BSP did not include interventions relative to inappropriate toileting.</p> <p>Interview with staff A on 10/13/20 verified that client #4 often soils his clothes and does not consistently alert staff when he needs assistance in using the bathroom. Further interview with staff A verified that client #4 will often take off his adult briefs and soil on the floor. Staff A confirmed during the interview on 10/13/20 that client #4 took off his adult briefs and urinated while standing in front of his bed. Interview with the qualified intellectual disabilities professional (QIDP) verified that client #4 has a history of soiling his clothes and thought that client #4's toileting accidents had improved. QIDP confirmed during the interview that client #4's goals were current. Continued interview with the QIDP confirmed that client #4 could benefit from training objectives relative to inappropriate toileting.</p> <p>During the follow up survey on 1/8/2021, the facility failed to provide corrective measures associated with the deficiency initially cited. Interview with the QIDP on 1/8/21 confirmed that the POC was not completed for this deficiency as</p>	{W 227}	<p>DHSR - Mental Health</p> <p>JAN 28 2021</p> <p>Reg. & Cert. Services</p>		

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: 34G317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/08/2021
NAME OF PROVIDER OR SUPPLIER LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 5927 LAKEVIEW DRIVE CHARLOTTE, NC 28270		
(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 227}	Continued From page 2 submitted.	{W 227}			

DHSR - Mer
JAN 2
Lic. & C