PRINTED: 04/20/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		MHL096-092	B. WING		R <b>04/05/2022</b>
<b>-</b>			DDDECC CITY CTA	TE 7/D 00DE	1 0 1100/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE  EVIEW DRIVE	TE, ZIP CODE	
LAKEVIEV	V		BORO, NC 27530		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual and follow on April 5, 2022. A de	up survey was completed eficiency was cited.			
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.				
This facility is licensed for 6 beds and currently					
	has a census of 6. To faudits of 3 current	he survey sample consisted clients.			
V 118	V 118 27G .0209 (C) Medication Requirements		V 118		
	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons transfer of the privileged to prepare (4) A Medication Admall drugs administered current. Medications	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The			
	<ul><li>(A) client's name;</li><li>(B) name, strength, a</li><li>(C) instructions for ac</li><li>(D) date and time the</li></ul>	nd quantity of the drug;			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER.	A. BUILDING:		COWFLETED	
	MHL096-092 B. WING			R <b>04/05/2022</b>		
NAME OF PROVIDER OR SUPPLIER STREET ADDI			DRESS, CITY, STA	TE, ZIP CODE		
LAKEVIE\	N		VIEW DRIVE			
	•	GOLDSBO	PRO, NC 27530	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 1	V 118			
	(5) Client requests for checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
	facility failed to admin written order of a phy three clients (#2, #4 a Finding 1 Review on 04/05/22 or revealed: -60 year old male. -Admission date of 02 -Diagnoses of Trauma	ews and interviews, the hister medications on the sician affecting three of and #5). The findings are:  of client #2's record				
	orders dated 02/10/2: -Buspirone HCL 30m; by mouth twice a day -Breo Ellipta 100-25 N dailyVitamin D3 1000 uni one by mouth dailyFluoxetine HCL 20m mouth dailyMetamucil (Supplem morning.	g (Anxiety)-Take one tablet  MCG (COPD) One inhale  t capsule (Supplement) Take g (Antidepressant) One by  ent) Take 4 capsules in the				
	Review on 04/05/22 of	of client #2's January-March				

Division of Health Service Regulation

STATE FORM PV0Y11 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		1 ' '	E SURVEY PLETED	
MHL096-092		B. WING			R <b>04/05/2022</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	•		
LAKEVIEW		EVIEW DRIVE BORO, NC 27530				
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
-Vitamin D3 1000 units-Fluoxetine HCL 20mg-Metamucil-03/20/22.  During interview on 04/-He had missed some of because it was not sense finding #2 Review on 04/05/22 of revealed: -48 year old maleAdmission date of 03/3-Diagnoses of Traumati Disorder, Dementia, Hy Review on 04/05/22 of orders dated 02/10/22 re-Advair Diskus 250-50 letwice daily.  Review on 04/05/22 of 2022 MARs revealed the was not available to adden advair Diskus 250-50 letwice daily.  During interview on 04/-He received his medical	ne following medication minister: 02/07/22-02/10/22 at CG -02/16/22, 02/17/2202/20/2203/09/2203/09/2205/22 client #2 revealed: of his medications at to the facility	V 118				

Division of Health Service Regulation

STATE FORM PV0Y11 If continuation sheet 3 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
MHL096-092		B. WING		04/05/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKEVIEV	N	103 LAKEV	IEW DRIVE			
LAKEVIL	•	GOLDSBO	RO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	3	V 118			
	-Admission date of 08/18/98Diagnoses of Traumatic Brain Injury, Chronic Pulmonary Aspiration, Pharyngoesophageal Dysphagia, Chronic Respiratory Failure, Dependence of Supplemental Oxygen, Umbilical Hernia without Obstruction, Testicular Hypofunction.  Review on 04/05/22 of client #5's Physician orders dated 02/10/22 revealed: -Linzess 145 MCG capsule One by mouth 30 minutes before breakfastFluticasone Propionate 50 MCG Two sprays by nasal route once dailyVitamin B12 Cyanocobalamin 1000mg (Supplement) One by mouth daily.					
	via Handihaler by taki daily. -Symbicort 160-4.5 2 -Metoclopramide HCl before meals and at b -Vitamin D3 1000 unit	e contents of one capsule ing two inhalations once  puffs by mouth twice daily.  10mg Take one by mouth bedtime.  t One by mouth twice daily.  Two by mouth once a day.				
	2022 MARs revealed was not available to a -Linzess 145 MCG Ci 03/18/22, 03/19/22Fluticasone Propiona -Vitamin B12 Cyanoc -Tiotropium-01/25/22-Symbicort 160-4.5-0 02/1/22-02/02/22, 03/-Metoclopramide HCL	apsule-01/13/22, 01/14/22, ate 50 MCG-01/03/22. obalamin 1000mg-01/21/22. -01/28/22. 1/30/22-01/31/22, 10/22. -02/01/22.				
	-Vitamin D3 1000 unit -Omeprazole 20mg-0 During interview on 0					

Division of Health Service Regulation

STATE FORM PV0Y11 If continuation sheet 4 of 5

PRINTED: 04/20/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL096-092	B. WING		04	R / <b>05/2022</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	•			
LAKEVIE	W		EVIEW DRIVE SORO, NC 27530					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 118	revealed: -The medication has staff were not able to -When the medicatio contact the medical s medications for each  During interview on 0 Specialist revealed: -The staff sends requipage -She was aware that be administered due  Due to the failure to a medication administr	run out at the facility and the give the medication. n is getting low the staff will specialist that handles the facility.  14/05/22 the Medical lest for refills for the facility medication was not able to to not being available.  accurately document ation it could not be received their medications	V 118					

Division of Health Service Regulation

STATE FORM PV0Y11 If continuation sheet 5 of 5