STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G317	A. BUILDING _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW	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
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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

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E 015	Continued From page 1	E 015		

hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to implement the emergency preparedness policy relative to the provision of subsistence food and water supply needs for clients and staff as required in the facility's emergency operations plan (EOP). The finding is:

Observations in the group home on 3/22/23 revealed a locked pantry in the facility's basement area. Continued observation revealed a well-stocked pantry full of emergency food and water. Observations also revealed numerous jars of food that were discolored and expired. Further observations revealed all of the food and water items to be expired. Observations revealed the following expired food items: 22 cans of vegetables (expired 9/1/20), 9 cans of tuna (expired 7/12/22), (12) 4-packs packs of jello and pudding (expired 12/16/20), several cans of fruit (expired 9/1/22), 5 lbs. of sugar (expired 12/1/20), 25 jars of baby food (expired 2/20/20) and 8 gallons of water (expired 3/14/20).

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E 015	Continued From page 2 Review of the facility emergency operations plan dated 9/27/21 did not reveal the contents of the emergency food supply and when food should be checked and rotated to ensure it does not expire. Continued review of the plan revealed the facility should maintain at least a three day supply of non-perishable food and water for clients and staff. Further review of the plan revealed a staff in-service dated 9/27/21 relative to the emergency operations plan. Interview with staff D on 3/22/23 revealed he was not aware of how often emergency food is rotated to ensure it does not expire. Continued interview with staff D revealed he was new to the company and had not been trained on food supply contents and how much food and water should be available to clients and staff. Interview with staff D revealed he would contact the interim residential team lead (RTL) to get clarification. Interview with the interim RTL on 3/22/23 revealed he was not aware how often the emergency food supply should be checked and/or rotated to ensure that it does not expire. Interview with the qualified intellectual disabilities professional (QIDP) and facility administrator revealed staff should check the emergency food supply every six months and rotate the food and water to ensure that it does not expire.	E 015		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.	W 262		

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W 262	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 4 of 6 clients (#1, #3, #4 and #5). The finding is: Observations throughout the survey from 3/21/23-3/22/23 revealed door chimes on the front, side and back doors of the facility. Continued observation revealed the doors to chime as staff entered and exited the facility. Review of the client record on 3/22/23 revealed human rights limitation consent for client #3 could not be found in the client record. Review of the record did not reveal current HRC limitation consents for clients #1, #3, #4 and #5. Continued review of the record for clients #1, #4 and #5 revealed HRC consents to be expired on the following dates: client #1 (expired 1/3/23), client #4 (expired 2/15/23) and client #5 (expired 11/24/22). Interview with the facility administrator on 3/22/23 revealed human rights limitation consents for clients #1, #3, #4 and #5 were completed but could not be located during the survey. Continued interview with the facility administrator revealed clients' human rights limitation consents should be reviewed and approved by the human rights committee annually.	W 262		