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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS An annual and complaint survey was completed on May 1, 2025. The complaints were substantiated (Intakes #NC00228977 and #NC00229032). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 2 former clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. A Suspension of Admission and a Summary Suspension to Operate were issued on May 1, 2025.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G	V 108		

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V 108	Continued From page 1 .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide training to meet the MH/DD/SAS needs of the clients affecting 3 of 5 current staff (Staff #1, House Manager (HM), and Associate Professional (AP)) and 4 of 5 former staff (Former Staff (FS) #2, FS #3, FS #4, and Former AP (FAP)). The findings are: Review on 4/23/25 of Staff #1's record revealed: -Hire date: 1/27/25. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Review on 4/23/25 of FS #2's record revealed: -Hire date: 3/10/25. -Date of separation: 4/9/25.	V 108		

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V 108	Continued From page 2 -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Review on 4/23/25 of FS #3's record revealed: -Hire date: 3/31/25. -Date of separation: 4/6/25. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Review on 4/23/25 of FS #4's record revealed: -Hire date: 3/20/25. -Date of separation: 4/7/25. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Review on 4/8/25 of the HM's record revealed: -Hire date: 8/2/24. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Attempted record review on 4/21/25 of the Former Associate Professional (FAP)'s record revealed no record. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FAP hire date: 1/20/25. -The FAP date of separation: 3/22/25. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis	V 108		

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V 108	Continued From page 3 plans. Review on 4/8/25 of the AP's record revealed: -Hire date: 3/24/25. -No documentation of training on the needs of the clients including, but not limited to, treatment plans and strategies, and implementation of crisis plans. Interview on 4/14/25 with Staff #1 revealed: -Did not have training on the needs of the clients. -"[FAP] told me I could review their (clients) binders (records) for their background information." Interview on 4/15/25 with FS #2 revealed: -"Didn't have any training about how to handle situations and strategies to meet client needs." -The "only" training on the needs of the client's she had was "[FAP] made me read through the client files (records)." Interview on 4/9/25 with the HM revealed: -Reviewed the clients treatment plans to understand the needs of the clients. -She "did not take training on the clients' needs." -Client #1's verbal aggression and suicidal ideation "makes us (staff) feel unsafe (in the facility)." -Client #1 cursed at her and she felt "unsafe with him today (4/9/25)." Interviews on 4/14/25 and 4/16/25 with the FAP revealed: -Did not have "specific trainings" on the needs of the clients. -Reviewed the information in the clients' records to learn the needs of the clients. Interviews on 4/15/25 and 4/16/25 with the	V 108		

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V 108	Continued From page 4 Former Qualified Professional (FQP) revealed: -There was no training completed on how to meet the needs of the clients. -"Didn't see or experience it (training) for myself or for staff..." -There was no documentation of the needs of the clients being discussed with staff in staff meetings. -"[D/L/QP #2] was supposed to provide training on service notes, but training was never provided." -Never had training on how to de-escalate crisis situations with clients. -Asked the D/L/QP #2 for additional trainings for staff and herself on the needs of the clients but "[D/L/QP #2] never followed through with giving us (staff) the help needed, or training needed." Interview on 4/15/25 with the AP revealed: -Learned about the needs of the clients by reviewing the clients' treatment plans and Comprehensive Clinical Assessment. Interview on 4/15/25 with the QP #1 revealed: -Training on the needs of the clients were "ongoing" by ensuring that staff review clients' treatment plans, goals, and strategies. Interviews on 4/8/25, 4/15/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -Was responsible for ensuring staff receive required trainings. -Staff were trained on the needs of the clients by talking with the staff and instructing them to review the clients' treatment plans. -"Thought staff would do it (review clients' treatment plans and records) on their own but found out they did not." -"Can show staff a book (clients' records) but they won't read (clients' records)."	V 108		

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V 108	Continued From page 5 -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109		

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V 109	Continued From page 6 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 3 of 3 qualified professionals (Qualified Professional (QP) #1, Former QP (FQP), and Director/Licensee/QP #2 (D/L/QP #2)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 4/8/25 of the QP #1's record revealed: -Hire date: 11/1/21. -Job description responsibilities signed by the QP #1 and the D/L/QP #2 dated 5/11/23 included: "-Qualified Mental Health Professional (QMHP) provides support to clients diagnosed with mental health conditions. Specific responsibilities are conducting mental health assessments, creating personalized treatment plans, organizing therapy sessions, supervising course of treatment and assessing results and referring/linking clients to health professionals. -Provides services on an intensive basis utilizing short-term. Solution focused treatment strategies to clients and families.	V 109		

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V 109	Continued From page 7 -Facilitates care coordination with other services providers to enlist existing supports in determining and meeting service objectives and to identify additional resources and supports. -Prepares written service plans and treatment update summaries, incorporating input from clients, other service providers, wraparound team members to identify problem areas and needs, service objectives, and intervention strategies. -Provides direct clinical services to clients, including individual and family interventions. -Responds to crisis situations with twenty-four hour and day availability. -Completes progress reports in reference to service delivery within 48 hours. -Participates in child specific Family Assessment and Planning Team (FAPT) and other interdisciplinary, diagnostic, or planning meetings. -Link clients with external programs or services, such as: health services, recreational activities, childcare services, financial resources, housing placement, employment resources, childcare, AA/NA (Alcoholics Anonymous/Narcotic Anonymous) groups, transportation resources, and others. -Meets supervisor 2x (times) per month for service delivery and collateral contact review, chart audits, case staffing, individual training, self-care check-in, and employee development planning. -Attends bi-weekly staff meetings, group supervisions, and/ or trainings." Attempted record review on 4/21/25 of the FQP's record revealed no record. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FQP hire date: 1/10/25.	V 109		

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V 109	Continued From page 8	V 109		

-The FQP date of separation: 3/23/25.
-There was no job description in the record.

Requests for the FQP's job description were made to the D/L/QP #2 on 4/28/25 and 4/29/25. The job description was not provided by the time of the survey exit date.

Review on 4/9/25 of the D/L/QP #2's record revealed:
-Hire date: 6/1/11.
-Job description responsibilities signed by the D/L/QP #2 dated 5/16/23 included:
"-The Director has full administrative responsibility for the operation of H.O.P.E United, Inc. (Licensee).
-The Director is responsible for establishing policy and assuring the overall quality of services provided through regular monitoring and evaluating.
-The Director shall be responsible for the daily management of the program, which shall include but not limited to ensuring the service quality well as effective, efficient program outcome.
-The Director is responsible for the major decisions affecting H.O.P.E. United, Inc. services.
-Maintain open communication with consumers, families, LME (Local Managment Entity) (Local Management Entity/Managed Care Organization (LME/MCO))/County programs and employees.
-Writes reports, documentation and related paperwork clearly, concisely and timely.
-Informs the board regarding operation of the state through telephone conversation, reports and visits.
-Develop and implements a training program for all Supervisory Personnel.
-Ensures that staff performance evaluations

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V 109	Continued From page 9	V 109		

are completed in a timely manner.
-Effectively supervises staff and operations.
-Foster an atmosphere of growth, development and teamwork.
-Ensures that quality services are provided on a consistent basis by providing appropriate supervision of services.
-Conduct periodic audit of services and service provision. Documents to assure quality and accuracy.
-Create/Design System to ensure that services are supervised and implemented according to the mission of the company.
-Develops/Implements retention policies to limit staff turnover."

Refer to V108 for failure to meet personnel requirements:
-Staff not being trained in the mental health and substance abuse needs of the clients prior to the delivery of services.

Refer to V111 for failure to complete Assessments:
-Admission assessments were not completed for Client #1, #2 and Former Client (FC) #3.

Refer to V112 for failure to develop and implement treatment strategies:
-Treatment plans completed by a previous provider and not reviewed by the facility.
-No treatment plan based on initial assessment.
-Client goals and staff interventions not implemented.

Refer to V113 for failure to show documentation of progress towards outcomes:
-Failed to maintain documentation of services and staff interventions.
-Failed to develop a face sheet in the clients'

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V 109	Continued From page 10 records. Refer to V294 for failure to ensure QP responsibilities were completed: -Failed to perform clinical and administrative responsibilities a minimum of 10 hours each week and 70% of the time occurred when children or adolescents were awake and present in the facility. -Failed to ensure the supervision of the Associate Professional (AP), oversight of emergencies, provision of direct psychoeducational services, participation and coordination of treatment plans, and provision of case management functions. Refer to V295 for failure to ensure Associate Professional (AP) responsibilities were completed: -Failed to employ a full-time AP. -Failed to ensure management of the daily operations of the facility, supervision of paraprofessionals, and participation in service planning meetings. Refer to V296 for failure to provide minimum staffing ratios: -Failed to provide required staff to client ratios. Refer to V297 failure to ensure Licensed Professional responsibilities were completed: -Failed to ensure clinical supervision and overall programmatic issues of the facility. -Failed to ensure clients received therapy services and participation in treatment plans. Refer to V364 for failure to ensure client rights in 24-hour programs: -Failed to provide each minor client the opportunity to maintain private contact with their legal guardians.	V 109		

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V 109	Continued From page 11 Refer to V366 for failure to implement their incident reporting policy: -Failed to provide a response to address incidents and the patterns of behaviors. Refer to V367 for failure to complete Level II incident reports: -Level II incident reports were not completed within 72 hours. -Level II incident reports were not completed when law enforcement was contacted due to client behavior. Refer to V513 for failure to promote a respectful environment using the least restrictive and most appropriate settings and methods. -Clients placed on "lockdown" from 3/19/25-3/24/25 and instructed to stay in their bedrooms and only allowed out of their bedrooms to eat, use the bathroom, and be administered medications. Refer to V536 for failure to train staff in alternatives to restrictive interventions: -D/L/QP #2 did not ensure all staff were trained in alternatives to restrictive interventions. Interviews on 4/15/25 and 4/17/25 with the QP #1 revealed: -Started working as the facility's QP on 3/26/25. -Was supervised by the D/L/QP #2. -Was responsible for developing and updating the client treatment plans, goals and strategies. -Developed Client #1 and Client #2's treatment plan dated 3/26/25. -Was not sure why Client #1's treatment plan dated 3/26/25 had a physician signature dated 2/20/25. "No idea why." -Client #1 had a history of elopement from his	V 109		

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V 109	Continued From page 12	V 109		

previous placement. There were no strategies to address the elopement behaviors but "staff need to make sure they keep a watch on him...no going outside by himself (Client #1)."
-Assisted the D/L/QP #2 archive the service notes.
-Was not aware that clients could make and receive calls one day per week on their assigned call day. "(Clients) should be able to ask to make a call whenever they want to."
-The AP and the QP #1 were responsible for completing the Incident Response Improvement System (IRIS) reports.
-Was not aware clients were on a "lock down" where the clients had to remain in their bedrooms during free time and were only allowed to come out when they asked to use the bathroom, when meals were ready, and when medications were administered from 3/19/25-3/24/25.

Interviews on 4/15/25, 4/16/25, 4/17/25, and 4/25/25 with the FQP revealed:
-Was responsible for supervision of direct care staff and the AP.
-Was supervised by the D/L/QP #2.
-Visited the facility "maybe once every other week" and "wouldn't go in (visit facility) often."
-The D/L/QP #2 was responsible for scheduling staff trainings.
-There was no training for the needs of the clients, "didn't see or experience it for myself or for staff."
-"[LME/MCO] came out in February (2025) and told us before letting clients in (admitting) we're supposed to do admission assessments, and we didn't know that."
-Did not complete an admission assessment for any client.
-When she started as the QP for the facility, the clients were "working off of the goals given to

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V 109	Continued From page 13	V 109		

them from prior placement" and these goals were not reviewed and/or updated by the current treatment team.
-The Former Associate Professional (FAP) and the FQP created new goals for the clients. "When we came in (started work at the facility) there was nothing, no goals and no Person Centered Plans (PCP)."
-FC #3's PCP was created without FC #3's treatment team.
-"[D/L/QP #2] was supposed to provide a service note training, but training was never provided."
-She was responsible for developing and maintaining the client records for the facility and "wasn't informed" that an identification face sheet was required for each client record.
-She requested training from the D/L/QP #2 on the needs of the clients, responsibilities of the QP position, alternatives to restrictive interventions, and did not receive the requested trainings. "Didn't get it (trainings) the whole time (while QP of facility)."
-Scheduled one staff per shift as instructed by the D/L/QP #2. "As long as I was there, it was one staff on shift."
-The D/L/QP #2 ignored her requests to have two staff on shift at all times.
-The D/L/QP #2 had the final call on the staffing schedule.
-Clients could only make and receive calls one day per week on their assigned call day which was a system that was in place prior to her starting work with the facility.
-The clients missed scheduled therapy appointments due to staff not taking them.
-There was no follow up with staff about the missed therapy appointments other than informing staff to reschedule the therapy appointment and confirm the clients went.
-"Hard to take clients to appointments with one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 109	Continued From page 14	V 109		

staff on shift...think staffing may have been the issue why appointments (therapy) were missed."
-Instructed staff to document incidents, "a lot of times it (incident reporting) wasn't done."
-Was responsible for completing IRIS reports for the facility but "was not aware of the IRIS reporting requirements."
-She "had no training on how or what to do with the IRIS report, doing everything to the best of my ability with no training."
-As a consequence to client behaviors, the D/L/QP #2, the FAP and the FQP made the decision to put the clients on "lockdown" effective 3/19/25 where clients had to remain in their bedrooms during any free time outside of school and could only come out of their bedrooms when asked to use the bathroom, was administered medications or at mealtimes.
-"Don't think it (lockdown) was helpful for client behaviors...helped staff feel safe."
-Asked the D/L/QP #2 for additional trainings for staff and the FQP on the needs of the clients but "[D/L/QP #2] never followed through with giving us (staff) the help needed or training needed."
-She "asked [D/L/QP #2] several times for assistance, additional help, asking for job duties, additional trainings on the needs of the clients and facility responsibilities myself and staff" and never got it.
-"[D/L/QP #2] never followed through with giving us (staff and FQP) the help needed or training needed."
-"[D/L/QP #2] just didn't know and he couldn't provide answers to the questions we had."

Interviews on 4/7/25, 4/8/25, 4/9/25, 4/15/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed:
-Supervised the QP#1 and FQP.
-Hired the FQP and did not have her signed job

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 109	Continued From page 15 description nor staff files and could not identify where the files were located, "I don't know." -"Staff who left were responsible for the notes, incident reports, client files, intake assessment, treatment plans, and everything they were supposed to be doing wasn't done." -"I thought everything was getting handled..." -Did not provide oversight to the FQP, "...was not checking behind the QP (FQP)." -The facility did not have an assigned Licensed Professional to provide face to face clinical consultation in the facility at least four hours a week that included clinical supervision of the QP. -Thought admission assessments were being completed, but that "wasn't done." -The FQP was responsible for creating the treatment plans, "I am expecting it (treatment plans) to be done, not expecting to hear I need assistance on this." -Was not involved in the treatment plans dated 3/26/25 for Client #1, Client #2 and FC #3, "...I didn't handle that...[QP #1] created the new PCPs (treatment plans dated 3/26/25)." -The clients' goals and service notes were not done correctly because he "just assumed things were being done." -Created the AP work schedule, "...not really full time on shift." -Was unable to confirm if Client #1 received therapy prior 3/26/25, "...trying to implement more therapy now...not sure who therapist is...would have to ask [the HM] who they are." -Was "under the impression [FQP] and [FAP] were making therapy appointments." -Clients have a "designated day to make phone calls" which "is a supervised call" and are monitored by being on speaker phone. -"Designated call day not in policy and procedure for facility, just a conversation we had with guardians and clients and what times."	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 109	Continued From page 16 -Did not consider clients having a one day per week assigned call day "a restriction." -The facility did not have a Human Rights Committee, "trying to develop that." -The QP #1, the AP and the D/L/QP #2 were responsible for completing incident reports for the facility. -"I am learning the differences between level 1, 2, and 3 incidents now." -As a consequence to client behaviors, he approved for "lockdown" where the clients remained in their bedrooms during any free time, only to come out when they asked to use the bathroom, when meals were ready and when medications were administered from 3/19/25-3/23/25. -Did not believe the clients on "lockdown" from 3/19/25-3/24/25 was effective in correcting behaviors. -Was responsible for ensuring staff received required trainings. -"New hire training was staff came in and got core trainings, 2-3 days of trainings, some people slip through the cracks (staff did not get training)." -The staff that didn't have the alternative to restrictive interventions training was because the facility policy was that staff "had 90 days to get staff trained in alternatives to restrictive intervention, "...thought it was okay." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 109	Continued From page 17 NCAC 27G .1701 (V293) Scope for a Type A1 violation and must be corrected within 23 days.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 111	Continued From page 18	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure admission assessments were completed prior to the delivery of services affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3) . The findings are:

Review on 4/8/25 of Client #1's record revealed:
-Date of Admission: 2/14/25.
-Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression.
-Age: 17 years.
-No documentation of an admission assessment completed prior to receiving services at the facility.

Review on 4/8/25 of Client #2's record revealed:
-Date of Admission: 2/14/25.
-Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder.
-Age: 10 years.
-No documentation of an admission assessment completed prior to receiving services at the facility.

Review on 4/8/25 of FC #3's record revealed:
-Date of Admission: 2/14/25.
-Date of Discharge: 3/20/25.
-Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis and Enuresis.
-Age: 9 years.
-No documentation of an admission assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 111	Continued From page 19	V 111		

completed prior to receiving services at the facility.

Interview on 4/15/25 with the Former Qualified Professional (FQP) revealed:
-Started working in the facility "middle of January (2025)" and quit around "middle of March (2025)."
-Did not complete an admission assessment for any clients.
-"[Local Management Entity/Managed Care Organization (LME/MCO)] came out in February (2025) and told us before letting clients in (admitting) we're supposed to do admission assessments, and we didn't know that."
-"Asked [Director/Licensee/QP #2 (D/L/QP #2)] several times for assistance, additional help, asking for job duties, additional trainings on the needs of the clients and faciity responsiblities for myself and staff and never got it."

Interviews on 4/15/25 and 4/17/25 with the Qualified Professional (QP) #1 revealed:
-Started working as the facility's QP on 3/26/25.
-The Associate Professional (AP) and the QP #1 were responsible for client admission assessments, "haven't had to do one yet."

Interviews on 4/7/25, 4/8/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed:
-Supervised the QP #1 and the FQP.
-"Staff (FQP and Former Associate Professional (FAP)) who left were responsible for the intake (admission) assessment and everything they were supposed to be doing wasn't done."
-The QP #1 was expected to oversee the FQP and the FAP but "didn't work out that way because a lot of times he (QP #1) may have not stepped in (to provide supervision and direction) and I had to step in."
-There were no admission assessments for Client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 111	Continued From page 20 #1, Client #2, and FC #3 prior to their receiving services at the facility. -"I thought everything (including admission assessments) was getting handled." -Did not provide oversight to the FQP. -Thought admission assessments were being completed but "...wasn't done..." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 111		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 21 (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure treatment strategies were developed, current and implemented to address clients' needs affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3). The findings are: Review on 4/8/25 of Client #1's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression. -Age: 17 years. -Comprehensive Clinical Assessment (CCA) dated 3/20/25: -"Client has had a history of self-harm but reports that it has been more than a year since last incident...Client's group home staff have reported concerns about client becoming aggressive with other children, particularly younger children." -Person Centered Plan (PCP) completed by the Qualified Professional (QP) #1 dated 3/26/25:	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 22 -Physician's signature on the plan was dated 2/20/25 which was 33 days prior to the development of the plan. -Community Living: "[Client #1] cannot be around other peers in his current level 3 home due to behaviors." -Healthy Living: "[Client #1] has expressed that he does use marijuana and uses it while at school or places other than his home." -Goal 1: "[Client #1] will remain in his level 3 facility in the designated area and follow all house rules and procedures within the facility...Staff will: help [Client #1] identify situations, thoughts and feelings that trigger behavioral actions...assist [Client #1] to identify the positive consequences of managing frustration and anger...provide a staff secured and structured therapeutic environment designated to maximize the opportunity to improve the [Client #1's] level of functioning...provide immediate staff support/supervision for [Client #1] directed and managed activities in all identified need areas...assist guardian with developing a behavioral chart to assist [Client #1] with being held accountable for his actions in the home, school and community." -Goal 2: "[Client #1] will work cooperatively with treatment to develop a plan that includes how he will improve his grades and academic challenges by maintaining and reporting good grades.." No treatment strategies were identified. -Goal 3: "[Client #1] will learn appropriate socialization skills, anger management skills and reduce behaviors, and incidents of property destruction. [Client #1] will reduce his incidents of aggression to no more than 1 incident per week...Staff will: teach and reinforce appropriate communication and anger management techniques...use modeling and role-playing exercises to demonstrate effective	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 23	V 112		

responses...de-escalate techniques to help [Client #1] manage emotions before his aggression escalates...guide [Client #1] in participating in positive activities that will engage his time and his mind...[Client #1] will: actively participate in groups designed to enhance his interpersonal and communication skills...utilize natural supports and link and coordinate with program and services that address his needs...verbalize a commitment to abstain from the use of substances and minimize the amount of drug use and realize its negative impact on his life.

-Goal 4: "[Client #1] will verbalize a commitment to abstain from the use of substances and minimize the amount of drug use and realize its negative impact on his life. [Client #1] will reduce his substance use to less than 3 times a month...communicating effectively with his therapist on possible relapses...engaging in therapy services and participate in group sessions 3x (times) per week for three hours to address his marijuana use...Staff will assist and encourage [Client #1] to attend self-help meetings multiple times per week...research and attend local self-help groups/meetings and programs to identify a meeting place and time...[Client #1] will: find a hobby, volunteer, or find an activity to relax, to cope and handle stress and take the mind off using substances to relieve stress...participate and interact in all group meeting settings such as self-help groups (SAIOP (Substance Abuse Intensive Outpatient Program) and AA (Alcoholics Anonymous))...will continue to attend SAIOP weekly and fully engage in the group and be encouraged by his SAIOP counselor to fully engage in the program...natural supports will: Attend AA meetings with [Client #1] as he allows...natural supports will: encouraged [Client #1] to fully engage in the SAIOP program."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 24 -Goal 5: "[Client #1] will complete assigned daily chores and personal hygiene tasks independently at least 5 out of 7 days per week...identifying and utilizing appropriate community resources...[Client #1] will participate in psycho-educational groups and activities around hygiene and household skills." -There was no evidence that any of the above goals or treatment strategies were implemented. -No treatment strategies to address elopement. Interviews on 4/9/25 and 4/24/25 with Client #1 revealed: -Did not know his PCP goals. -He had "no say so with goals in PCP...no input into it" and the facility staff "never went over PCP with me." -When he was upset "no staff would try to talk to me...offer me anything to help calm me down." Review on 4/23/25 of email correspondence from the House Manager (HM) to Client #1's Mother/Legal Guardian dated 4/15/25 revealed: -"[HM] sent you a document to review and sign." -"Please sign and return ASAP (as soon as possible)." Interview on 4/23/25 with Client #1's Mother/Legal Guardian revealed: -On 4/15/25 the HM sent an email which requested her to review and sign Client #1's PCP. -There was "no meeting about it (development of Client #1's PCP), no explanation about updates for it (PCP) or why the PCP needed a signature." -The PCP attached to the 4/15/25 email sent by the HM on 4/23/25 was "..only plan ever signed..." -"Not sure what the 3/26/25 treatment plan (PCP) is about." -"Nobody talked to me about continuing substance use therapy for Lakeview (facility), they	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 25	V 112		

are not even drug testing [Client #1] at the home (facility)."
-Client #1 went to SAIOP while at his previous placement but did not continue with SAIOP while at the facility.
-Did not think Client #1 went to AA meetings.

Review on 4/8/25 of Client #2's record revealed:
-Date of Admission: 2/14/25.
-Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder.
-Age: 10 years.
-Undated PCP with no signatures by the Department of Social Services Legal Guardian (DSS LG) or other members of the treatment team.
-Goal 1: "[Client #2] will learn to manage his anger and aggression more appropriately by expressing his feelings in a nonphysical manner..." No treatment strategies were identified.
-Goal 2: "[Client #2] will address issues underlying depressive feelings and correct irrational thinking as evidence by accepting that his depression is causing his problems and changing his thought process..." No treatment strategies were identified.
-Goal 3: "[Client #2] will complete assigned daily chores and personal hygiene task independently..." No treatment strategies were identified.
-Goal 4: "[Client #2] will set appropriate boundaries for himself and others and follow the rules and directives given him..." No treatment strategies were identified.
-PCP completed by the QP #1 dated 3/26/25:
-"Community Living: [Client #2] does not engage much in the community. This will be an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 26	V 112		

ongoing goal moving forward for more community engagement."

-"Healthy Living: [Client #2] has a history of encopresis and experienced it daily for several weeks. [Client #2] has severe behaviors at times and will threaten and attempt to harm himself at school and in the home. [Client #2] is only on one medication."

-Goal 1: "[Client #2] will learn to manage anger more appropriately...staff will: assist [Client #2] with developing alternative coping choices...use role-play and behavioral rehearsal to teach assertiveness as a healthy alternative to aggressiveness...find fun and interactive activities for [Client #2] to indulge in."

-Goal 2: "[Client #2] will address issues underlying depressive feeling and correct irrational thinking as evidence by accepting that his depression is causing problems and changing his thought process...Staff will: teach the use of positive behavioral alternatives to cope with impulsive and mood swing urges...de-escalate techniques to help [Client #2] manage emotions before his aggression escalates...engage [Client #2] in pro social activities at least once per week...provide [Client #2] with educational materials about social and/or communication skills...[Client #2] will be motivated to complete his time in [local school academy] to return to a traditional school setting."

-Goal 3: "[Client #2] will complete assigned daily chores and personal hygiene tasks independently...[Client #2] will: participate in psycho-educational groups and activities around hygiene and household skills."

-There was no evidence that any of the above goals or treatment strategies were implemented.

-No treatment strategies to address Encopresis.

Interview on 4/24/25 with Client #2 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 27	V 112		

-PCP goals were "no aggression, be accountable."
-When he was upset staff would "offer for me to go to my room and chill."
-"...sometimes don't want to go to my room when I'm upset but still end up going."

Interviews on 4/16/25 and 4/25/25 with Client #2's DSS LG revealed:
-"Was told that [Client #2] was with his same age range at Lakeview (facility), didn't know a 17-year-old was going to be with [Client #2]."
-Signed PCP dated 3/26/25 but there was no PCP prior to that one.
-Was "expecting staff to work with him (Client #2) regarding needs and goals."

Review on 4/8/25 of FC #3's record revealed:
-Date of Admission: 2/14/25.
-Date of Discharge: 3/20/25.
-Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis and Enuresis.
-Age: 9 years.
-PCP dated 3/26/25 which was 6 days after FC #3 was discharged from the facility. There were no signatures on the PCP.
-PCP dated 8/6/24 which was more than 6 months prior to FC #3's admission to the facility. There were no signatures on the PCP. Goals were identified as:
-Goal 1: "Increase ability to manage bedwetting."
-Goal 2: "Complete assigned daily chores and personal hygiene tasks independently."
-Goal 3: "Learn and practice at least 3 anger management techniques."
-Goal 4: "Learn to use coping skills when he struggles with his emotions."
-There was no evidence that any of the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 28	V 112		

goals were reviewed by facility staff or were implemented.

Interview on 4/15/25 with Former Staff (FS) #2 revealed:
-Worked in the facility from 3/10/25-4/9/25.
-While working in the facility she heard a representative of the Local Management Entity/Managed Care Organization inform the Director/Licensee/QP #2 (D/L/QP #2) that "staff need training on how to write to goals."

Interviews on 4/15/25, 4/16/25, 4/17/25, and 4/25/25 with the Former Qualified Professional (FQP) revealed:
-Started working in the facility "middle of January (2025)" and quit around "middle of March (2025)."
-When she started as the QP for the facility the clients were "working off of the goals given to them from prior placement."
-The Former Associate Professional (FAP) and the FQP created new goals for the clients. "When we came in (started work at the facility) there was nothing, no goals and no Person Centered Plans."
-FC #3's PCP was created without FC #3's treatment team.
-"[D/L/QP #2] just didn't know and he couldn't provide answers to the questions we (FAP & FQP) had."

Interviews on 4/15/25 and 4/17/25 with the QP #1 revealed:
-Started working as the facility's QP on 3/26/25.
-Was supervised by the D/L/QP #2.
-Was responsible for developing and updating the clients' PCPs.
-Developed Client #1 and Client #2's PCP dated 3/26/25 by "talking with treatment team and guardians, met with the clients, looked at CCAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 29	V 112		

and formulated the PCP."
-Was not sure why Client #1's PCP dated 3/26/25 had a physician signature dated 2/20/25. "No idea why."
-He was aware Client #1's PCP identified that Client #1 can't be around other individuals due to aggression and that staff addressed this by "expected to be in arm's length from [Client #1] at all times."
-Client #1 had a history of running away from his previous placement and there were no strategies to address this behavior. "Staff need to make sure they keep a watch on him...no going outside by himself (Client #1)."
-Client #1 had not been set up for SAIOP or AA yet, "...called last week...haven't been able to find anything as of yet."
-He was not aware of Client #1's history of self-harm/suicidal ideation, "I don't know anything of him trying any self-harm."
-"Staff in the home (facility) before me was messed up...no idea why...want to help him (D/L/QP #2) find another QP that can do the QP requirements. Not looking to do this full term (work at the facility)."

Interviews on 4/7/25, 4/8/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed:
-Supervised the QP#1 and the FQP.
-"Staff who left were responsible for the treatment plans (PCPs) and everything they were supposed to be doing wasn't done."
-"I thought everything was getting handled."
-Did not provide oversight to the FQP.
-The FQP was responsible for creating the PCPs, "I am expecting it (PCPs) to be done, not expecting to hear I need assistance on this (creating PCPs)."
-Was not involved in the PCPs dated 3/26/25 for Client #1, Client #2 and FC #3. "I didn't handle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 112	Continued From page 30 that (PCPs)...[QP #1] created the new PCPs (3/26/25)." -The clients' PCP goals were not based off an initial assessment because he "just assumed things were being done." -Client #1 was not going to any substance use group 3 times per week as identified in Client #1's PCP dated 3/26/25. -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 113	Continued From page 31 (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the required documentation in the client's record affecting 2 of 2 current clients (#1 and #2) and 2 of 2 former clients (FC #3 and FC #4). The findings are: Review on 4/8/25 of Client #1's record revealed: -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 113	Continued From page 32 (ADHD); Anxiety; and Depression. -Age: 17 years. -No documentation of a face sheet to identify client's name, record number, date of birth, race, gender, marital status, and admission date. Interview on 4/7/25 with the Director/Licensee/Qualified Professional (D/L/QP #2) revealed: -Client #1's Date of Admission: 2/14/25. Review on 4/16/26 of Client 1's facility's service notes dated 2/14/25-4/10/25 revealed: -4 service notes were provided. The service notes were dated: 2/15/25 2nd shift, 2/19/25 2nd shift, 2/24/25 (shift not identified), and 2/25/25 (shift not identified). -The service notes were not signed by staff who completed the note, the Qualified Professional #1, or the Former Qualified Professional (FQP). -There was no other documentation of progress toward outcomes or services provided for the remaining 145 shifts in the review period of 2/14/25-4/10/25. Review on 4/8/25 of Client #2's record and interview with the D/L/QP #2 revealed: -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -No documentation of a face sheet to identify client's name, record number, date of birth, race, gender, marital status, and admission date. Interview on 4/7/25 with the Director/Licensee/Qualified Professional (D/L/QP #2) revealed: -CLient #2's Date of Admission: 2/14/25.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 113	Continued From page 33 Review on 4/16/26 of Client 2's facility's service notes dated 2/14/25-4/10/25 revealed: -47 service notes were provided. The service notes were dated: 2/14/25-2/28/25, 3/1/25-3/19/25, 3/23/25, 3/28/25, 3/29/25, 4/1/25, 4/3/25-4/7/25, and 4/9/25. -1 service note dated 2/15/25 was not signed by the staff who completed the note, the QP #1 or the FQP. -Purpose of contact on 3/7/25 and 3/8/25, "Do not argue with staff or peers, minding his own business." -Intervention on 3/7/25 and 3/8/25, "Client was directed to complete his nightly chores and also his nightly hygiene and did so without any extra prompts." -There was no other documentation of progress toward outcomes or services provided for the remaining 102 shifts in the review period of 2/14/25-4/10/25. Review on 4/8/25 of FC #3's record and interview with the D/L/QP #2 revealed: revealed: -Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis and Enuresis. -Age: 9 years. -No documentation of a face sheet to identify client's name, record number, date of birth, race, gender, marital status, admission date, and discharge date. Interview on 4/7/25 with the Director/Licensee/Qualified Professional (D/L/QP #2) revealed: -FC #3's Date of Admission: 2/14/25. -FC #3's Date of Discharge: 3/20/25.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 113	Continued From page 34 Review on 4/16/26 of FC #3's facility's service notes dated 2/14/25-3/20/25 revealed: -50 service notes were provided. The service notes were dated: 2/15/25-2/28/25, and 3/1/25-3/19/25. -There was no other documentation of progress toward outcomes or services provided for the remaining 47 shifts in the review period of 2/14/25-3/20/25. Review on 4/20/25 of FC #4's record and interview with the D/L/QP #2 revealed: revealed: -Diagnoses: Post Traumatic Stress Disorder, chronic; ODD; and ADHD. -Age: 10 years. -No documentation of a face sheet to identify client's name, record number, date of birth, race, gender, marital status, admission date, and discharge date. -No documentation of progress toward outcomes or services provided. Interview on 4/7/25 with the Director/Licensee/Qualified Professional (D/L/QP #2) revealed: -FC #4's Date of Admission: 2/14/25. -FC #4's Date of Discharge: 2/16/25. Interviews on 4/8/25 and 4/10/25 with the House Manager (HM) revealed: -Staff were expected to complete service notes after each shift. -1st shift weekday: 1:30pm-5pm. -2nd shift weekday: 5pm-10pm. -3rd shift weekday: 10:30pm-8am. -1st shift weekend: 7am-7pm. -2nd shift weekend: 7pm-7am. Interview on 4/15/25 with Former Staff (FS) #2	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 113	Continued From page 35	V 113		

revealed:
-Worked in the facility from 3/10/25-4/9/25.
-Was expected to write service notes after each shift.
-There "wasn't any training on how to write (service) notes, nobody showed me how to write (service) notes."
-Clients did not have face sheet in their records.
-Was informed of the client's emergency contact information as needed by the Former Associate Professional (FAP).

Interview on 4/14/25 with the FAP revealed:
-Worked in the facility from January 2025 until 3/20/25.
-The FQP and the FAP were responsible for creating face sheets for the clients' records.
-Started to create the face sheets but did not put them in the clients' records. "Asked the owner (D/L/QP #2) about the face sheets and he didn't know."
-Staff were expected to complete service notes after each shift.
-"[D/L/QP #2] didn't press issue of shift (service) notes in general...(service) notes turned in were not timely or (they were) incomplete notes."
-When she started the clients did not have goals established so she "told [D/L/QP #2] to write (service) notes we (staff) have to have goals (for the clients)."
-Did not receive training on how to complete service notes, "he (D/L/QP #2) had a friend that was going to come down and do training on shift (service) notes (with staff) but he canceled the training and never rescheduled."

Interviews on 4/15/25 and 4/25/25 with the FQP revealed:
-Started working in the facility "middle of January (2025)" and quit around "middle of March (2025)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 113	Continued From page 36 -Responsible for creating face sheets and ensuring service notes were up to date and signed. -Clients did not have face sheets in their records because "I wasn't informed of needing a face sheet in the client binders (records)." -"[Local Management Entity/Managing Care Organization (LME/MCO)] let us know info (information) was missing from client binders (records)." -When she reviewed the services notes, they were not completed by staff correctly as staff did not document services provided or progress toward outcomes. -"When it came to (service) notes, staff would say they are not doing (service) notes until they get paid." -Informed the D/L/QP #2 that the services provided and progress toward outcomes were not being documented correctly by staff. -"[D/L/QP #2] was supposed to provide training on service notes, but training was never provided. -She "didn't get around to review or sign March (2025) (service) notes" because the LME/MCO told the facility "so much to correct." -"[D/L/AP #2] asked me to sign the (service) notes before [LME/MCO] came (February 2025). I wasn't able to review some of the (service) notes before signing off on them." Interview on 4/15/25 with the Associate Professional (AP) revealed: -Started working at the facility on 4/1/25. -Face sheets should be in the clients' records. -"Had to dig through the binders (clients' records) to get guardians info (information) and (phone) number. I was searching high and low." -She would create face sheets for the clients' records.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 113	Continued From page 37 Interviews on 4/15/25 and 4/17/25 with the Qualfied Professional (QP) #1 revealed: -Started working as the facility's QP on 3/26/25. -When he reviewed the client records, he "noticed there wasn't face sheets and told staff and [D/L/QP #2]." -The AP was responsible for creating face sheets for the clients' records. -Had signed the facility's service notes prior to 3/26/25 and helped the D/L/QP #2 with "queuing (reviewing) some of the notes for him." -"Staff in the home (facility) before me was messed up...no idea why...want to help him (D/L/QP #2) find another QP that can do the QP requirements, not looking to do this full term (work at the facility)." Interview on 4/9/25 with the LME/MCO representative revealed: -Did a routine visit of the facility around the "end of February (2025)." -Review of the facility revealed "progress (service) notes and documentation were not in compliance (client progress toward goals and staff interventions not documented)." -"Spent countless hours with him (D/L/QP #2)...they (staff) didn't know how to do paperwork." -"[LME/MCO] is having a meeting with [D/L/QP #2] next week (4/14/25-4/18/25)...everything (facility documentation) is out of compliance from top to bottom." Interviews on 4/7/25, 4/8/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -Supervised the QP#1 and the FQP. -"Thought we implemented the face sheet before; don't know why the client books (records) didn't have face sheets." -He will create and implement use of the face	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 113	Continued From page 38 sheets in the clients' records. -The FQP would review with staff how to complete services notes but "some people slip through the cracks (some staff did not review how to do service notes)." -"I thought everything was getting handled." -"Didn't check behind the QP (FQP and QP #1) and AP (FAP and AP). Assumed that it (facility documentation) was done." -The clients' service notes were not done correctly because he "just assumed things were being done." -"Staff who left were responsible for the (service) notes and client files and everything they were supposed to be doing wasn't done." -Identified that he was ultimately responsible for the service notes not being completed. -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 (V293) Scope for a Type A1 violation and must be corrected within 23 days.	V 113		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care	V 116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 39 practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication dispensing was restricted to pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 2 clients (#1). The findings are:	V 116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 40	V 116		

Review on 4/8/25 of Client #1's record revealed:
-Date of Admission: 2/14/25.
-Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression.
-Age: 17 years.
-Physician's orders dated 3/25/25:
-Qelbree ER (extended release) 200 milligrams (mg) (ADHD), 2 capsules (caps) every morning (QAM).
-Hydroxyzine 25mg (anxiety) 1 tablet (tab) every 6 hours (Q6H) as needed (PRN).
-Trazodone 100mg (sleep) 1 tab at bedtime (QHS).
-No physician orders for:
-Sertraline 25 milligram (mg) (depression) tablet (tab), 1 tab every day (QD).
-Sertraline 25mg 3 tabs QAM.
-Ziprasidone HCl (hydrochloride) 60mg (anti-psychotic), 1 cap twice daily (BID).
-Trazodone 50mg 1 tab QHS.
-Melatonin 10mg (sleep), 1 tab QHS PRN.

Further review on 4/29/25 of Client #1's record revealed:
-Two documents signed by Client #1's Mother/Legal Guardian.
- "On behalf HOPE United Inc. (Licensee) we release [Client #1] to his mother, [Mother/Legal Guardian] for a visit starting March 8, 2025 at 12:00PM through Sunday March 9, 2025 at 11:30AM... Staff will send all prescribed medications and correct times to be given (administered) ..."
-"On behalf HOPE United Inc. we release [Client #1] to his mother, [Mother/Legal Guardian] for a visit starting April 5, 2025 at 12:30PM through April 6, 2025 at 12 noon ...Staff will send all prescribed medications and correct times to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 41	V 116		

given (administered) ..."
-There was no documentation that Client #1's Mother/Legal Guardian received information regarding the medications and their administration instructions for the overnight visits.

Review on 4/8/25 of Client #1's MARs from 2/14/25 to 4/8/25 revealed:
-The following medications were documented as administered per the physican orders:
-Qelbree 200mg 2 caps QAM.
-Hydroxyzine 25mg 1 tab Q6H PRN.
-Trazodone 100mg 1 tab QHS.
-The following medications were documented as administered but there were no physician's orders in Client #1's record:
-Sertraline 25mg (depression), 1 tab QD.
-Sertraline 25mg, 3 tabs (75mg), QAM.
-Ziprasidone 60mg (anti-psychotic), 1 cap twice daily (BID) at 7am and 7pm.
-Melatonin 10mg (sleep), 1 tab QHS PRN.

Interview on 4/24/25 with Client #1 revealed:
-Staff provided him with more than one dose of medication when he went on overnight visits with his mother/legal guardian. The medications were given to his mother/legal guardian to be administered during the overnight visit.

Interviews on 4/16/25, 4/23/25, and 4/28/25 with Client #1's Mother/Legal Guardian revealed:
-Had two overnight visits with Client #1, one was in March 2025, and another was in April 2025.
-She picked Client #1 up from the facility between 10am and 2pm on Saturdays and would drop him back off on Sundays from 10am and 2pm.
-Staff required her to sign a paper to acknowledge receipt of Client #1's medications when Client #1 went on overnight visits with her.
-Staff provided two doses of Client #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 42	V 116		

medications for overnight visits, one dose for Saturday night and one dose for Sunday morning.
-Before she picked up Client #1 for overnight visits, the medications were already prepared in the plastic bags, with loose pills, and there were no more than 7 pills in each plastic bag.
-"Two to three meds (medications) in total (in each bag)."
-Could not identify which medications she administered to Client #1 as she "was not sure which meds were which."
-Administered Client #1 his medications on Saturday nights and Sunday mornings when he was at her home on overnight visits.
-Client #1's medications were never handed to her in a bubble pack, " ...bubble packs would not fit in the gallon (plastic) bag."
-"If [Client #1] didn't recognize his med, he would have said something."

Interview on 4/17/25 with Former Staff (FS) #2 revealed:
-Director/Licensee/QP #2 (D/L/QP #2) provided the instruction to staff on how to prepare Client #1's medications for overnight visits.
-D/L/QP #2 told the Former AP to "put the meds in a [Ziploc] bag, label it AM or PM, two separate bags, went over meds with mom, each individual pill was in its own bag, each dose, loose pills in bag, mini [Ziploc] bag, labeled each bag with which med it was and when to give (administer) it. Put all of the morning meds in a mini bag, and then in AM gallon bag, and PM meds in a gallon bag, AM and PM in two separate bags, each pill was in its own mini bag ...scared about that, certain medications not supposed to touch other medications."

Interview on 4/17/25 with the Qualified Professional #1 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 43	V 116		

-Aware of only one overnight visit for Client #1.
- "Should be a sign in and sign out sheet (at the facility) for meds and count them when they come back ...staff should call the pharmacy to pre-package the meds to give (Client #1's) mom (Mother/Legal Guardian] in..."
- "Didn't know about that (Client#1's medications placed in sealable plastic bags to be sent for overnight visits)."
- "Can't have loose pills."

Interview on 4/24/25 with the D/L/QP #2 revealed:
-When Client #1 went on overnight visits, "mom (Mother/Legal Guardian) signs what meds she's given ...mom signs a list of meds."
" ...Supposed to give mom the bubble pack, confirm how many meds are in there before leaving and count meds when they come back."
- "That's not the way we are supposed to do it (give Client #1's Mother/Legal Guardian Client #1's loose pills in a plastic bag)."
- "Didn't know meds were given loosely ...thought staff were giving bubble pack with instructions to mom (Mother/Legal Guardian)."
- "I don't believe in giving loose medication."
- "I can't say for sure because I wasn't there ... (this is the) reason why we got a RN (Registered Nurse) to review meds and letting staff know what's right to do for med pass for home visits."
-Acknowledged that the facility did not currently have an RN providing oversight of medications.

Interview on 4/29/25 with D/L/QP #2 revealed:
-Acknowledged that not all of Client #1's medications were in bubble packs as previously reported.
- "Thought they (staff) gave mom (Mother/Legal Guadian) the meds in bottles."
-Acknowledged that the document signed by Client #1's Mother/Legal Guardian for overnight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 116	Continued From page 44 visits did not identify the names of the medications, administration instructions for the medications, or identify the count of the medications present. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 116		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 45 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure that the medications were administered on the written order of a physician affecting 2 of 2 current clients (#1 and #2) and 2 of 2 former clients (FC #3 and FC #4) and failed to ensure the MARs were kept current for 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #4). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V116) Based on record review and interview, the facility failed to ensure medication dispensing was restricted to pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 2 clients (#1). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record review, interview, and observation, the facility failed to ensure that all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 2 clients (#1 and #2). Client #1 A. Medications were administered without physician's orders.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 46 Review on 4/8/25 and 4/11/25 of Client #1's handwritten MARs dated 2/14/25-4/8/25 revealed the following medications were documented as administered: February 2025 2/15/25-2/28/25: -Qelbree ER (Extended Release) (Attention Deficit Hyperactivity Disorder (ADHD)) 200 milligrams (mg) 2 capsules (caps) (14 days). -Sertraline (depression) 25mg 1 tablet (tab) (14 days). 2/14/25-2/28/25: -Ziprasidone HCl (Hydrochloride) (antipsychotic) 60mg 1 cap twice daily (BID) (15 days). -Hydroxyzine (anxiety) 25mg 1 tab BID (15 days). -Trazodone (sleep) 100mg 1 tab at bedtime (QHS) (15 days). -Melatonin (sleep) 10mg 1 tab as needed (PRN) QHS (14 days). March 2025 3/1/25-3/25/25: -Qelbree ER 200mg 2 caps (25 days). -Trazodone 100mg, 1 tab QHS (24 days). -Hydroxyzine 25 mg tab 1 tab every 6 hours (Q6H) PRN (24 days). 3/1/25-3/31/25: -Sertraline 25mg 3 tabs every morning (QAM) (31 days). -Ziprasidone HCl 60mg 1 cap BID (31 days). -Melatonin 10mg 1 tab PRN (31 days). April 2025 4/1/25-4/8/25: -Sertraline 25mg 3 tabs QAM (7 days). -Ziprasidone HCl 60mg (7 ½ days). -Melatonin 10mg 1 tab PRN QHS (7 days)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 47	V 118		

Observation on 4/8/25 at approximately 10:30am of Client #1's medications revealed:
-Qelbree 200mg dispensed 3/25/25.
-Sertraline 25 mg, 3 tabs (75mg) dispensed 2/26/25.
-Hydroxyzine 25mg dispensed 3/25/25.
-Ziprasidone HCl 60mg dispensed 2/26/25.
-Trazodone 50mg with administration directions of 1 tab QHS dispensed 3/3/25.
-Trazodone 100mg with administration directions of 1 tab QHS dispensed 3/25/25.
-Melatonin 10mg in a manufacturer's bottle with no pharmacy label.

Review on 4/11/25 of a list of Client #1's medications dispensed from a local pharmacy revealed:
-Sertraline 25mg, dispensed 12/18/24, qty 30 (30 days).

B. MARs were not kept current.

Review on 4/8/25 and 4/9/25 of Client#1's handwritten MARs dated 2/14/25-4/8/25 revealed:
-The following medications were initialed as administered:

February 2025
2/14/25-2/28/25:
-Hydroxyzine 25mg tab, 1 tab BID (14 days). The order was written as PRN. Hydroxyzine was scheduled on the MAR routinely rather than PRN as ordered.
-Sertraline 25mg tab, 1 tab QD (14 days). There was a dosage increase on 2/26/25 to 75 mgs (3 tabs) Sertraline QAM with no documentation on the MAR reflecting the change per dispensed medication.
-Ziprasidone 60mg, 1 cap BID, initialed as administered, 1 cap QD for 14 days (14 out of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 48 doses of Ziprasidone administered) March 2025 (3/1/25-3/31/25): -Qelbree, 200mg 2 caps QD (31 days). -Sertraline 25mg, 3 tabs, QAM (31 days). -Trazodone 100mg, 1 tab QHS (31 days). -Staff initialed that they administered 1 dose of Hydroxyzine, and 1 dose of Ziprasidone, 1 dose of Trazodone, and 1 dose of Melatonin from 3/8/25-3/9/25 when Client #1 was out of the facility. April 2025 (4/1/25-4/8/25): -Documentation of administration of 1 dose of Hydroxyzine, 1 dose of Ziprasidone, 1 dose of Trazodone, and 1 dose of Melatonin when Client #1 was out of the facility from 4/5/25 to 4/6/25. -Trazodone 50mg tab, 1 tab QHS was never documented on the MAR despite the order dated 3/3/25. -Trazodone 100mg tab, 1 tab QHS (7 days). Interview on 4/9/25 with Client #1 revealed: -Felt "agitated" and "terrible" due to missed medications. -"It was hard to sleep" when he ran out of Trazodone 100mg QHS. -Staff later got an appointment with a physician to get his Trazodone 100mg QHS renewed but the physician reduced the dosage to 50mg QHS. Interview on 4/16/25 with Client #1's Mother/Legal Guardian revealed: -There was a lack of communication from the facility regarding Client #1 missed medication. -If she had been made aware of medication issues, she would have contacted Client#1's former physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 49 -"He (Client #1) would have mood swings and agitation if he missed his medications." Client #2 A. Medications were administered without physician's orders. Review on 4/8/25 of Client #2's record revealed: -A Physician order dated 1/22/25 for: -Fluoxetine (depression) 20mg 1 tab daily QAM. -Physicians' orders dated 3/18/25 for: -Dexmethylphenidate (ADHD) 15mg 1 cap QAM. -Hydroxyzine 10mg 1 tab QHS PRN. -No physician order for: -Melatonin 1 mg. Review on 4/8/25 and 4/11/25 of Client #2's handwritten MARs dated 2/14/25-4/8/25 revealed the following medications were documented as administered: February 2025 2/14/25-2/28/25: -Dexmethylphenidate 15mg QAM (14 days). -Hydroxyzine 10mg 1 tab QHS PRN (1 day). -Melatonin 1mg 1 tab was documented as PRN and was also documented as administered at 7:00pm on the same MAR entry (15 days). March 2025 3/1/25-3/18/25: -Dexmethylphenidate 15mg QAM (18 days). -Hydroxyzine 10mg 1 tab QHS (12 days). -Melatonin 1mg 1 tab QHS (31 days). April 2025 4/1/25-4/8/25: -Melatonin 1mg 1 tab QHS (7 days).	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 50 Observation on 4/8/25 at approximately 10:40am of Client #2's medications revealed: -Dexmethylphenidate 15mg cap 1 cap QAM dispensed 3/18/25. -Hydroxyzine 10mg tab 1 tab QHS PRN dispensed 3/18/25. -Melatonin 10mg in a manufacturer's bottle with no pharmacy label. -Fluoxetine 20mg 1 cap QAM dispensed 3/12/25. B. MARs were not kept current. Review on 4/8/25 and 4/11/25 of Client #2's handwritten MARs dated 2/14/25-4/8/25 revealed the following medications were documented as administered: February 2025 2/14/25-2/28/25: -Melatonin 1mg 1 tab was documented as PRN and was also documented to be administered at 7:00pm on the same MAR entry (15 days). March 2025 3/1/25-3/31/25: -No documentation of administration of Fluoxetine 20mg 1 cap on 3/4/25 (1 day). -Documentation of administration of Hydroxyzine 10mg 1 tab QHS from 3/20/25-3/31/25 (11 days). -Staff failed to document Hydroxyzine 10mg 1 tab QHS PRN on the MAR which matched the 3/18/25 physician order. -Documentation of administration of 31 doses of Melatonin 1mg 1 tab QHS was administered nightly at 7:00pm (31 days) when it was previously identified on the February 2025 MAR as PRN. April 2025 4/1/25-4/8/25:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 51	V 118		

-Hydroxyzine 10mg 1 tab QHS. The facility failed to document it as a PRN dose. (7 days).

Interview on 4/9/25 with Client #2 revealed:
-"Felt like I had too much energy" if his prescribed medications were not administered as ordered.

Interview on 4/16/25 with Client #2's Department of Social Services Legal Guardian (DSS LG) revealed:
-Client #2 was hyper, had issues with impulsiveness, and needed support with emotional regulation.
-There was a lack of communication and organization with the facility.
-"Always find out after the fact ..."
-Not aware if Client #2 had missed medication.

Interview on 4/9/25 with Client #2's School Counselor revealed:
-Client #2 came to her office one time "because he was out of his meds (medications) and he was about to flip out."

FC #3
A. Medications were administered without physician's orders.
Review on 4/8/25 of FC #3's record revealed:
-Date of Admission: 2/14/25.
-Date of Discharge: 3/20/25.
-Diagnoses: ADHD, predominantly inattentive type; Oppositional Defiant Disorder; Major Depressive Disorder, single episode, moderate; Encopresis and Enuresis.
-Age: 9 years.
-Physician Orders Not Present:
-No physician's orders for:
-Sertraline 25mg 1 tab QD.
-Atomoxetine (ADHD) 18mg 1 cap QAM.
-Ketoconazole Shampoo (anti-fungal) apply 2-3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 52	V 118		

days per week.
-Melatonin 3mg 1 tab QHS.
-Cetirizine (allergies) 10mg 1 tab QHS.

Review on 4/8/25 and 4/11/25 of FC #3's handwritten MARs dated 2/14/25-3/20/25 revealed the following medications were documented as administered:

February 2025
2/14/25-2/28/25:
-Cetirizine 10mg 1 tab QHS (15 days).
-There were no other medications listed on the MAR.

March 2025 MAR
3/1/25-3/13/25:
-Ketoconazole Shampoo applied (5 days).
3/1/25-3/19/25:
-Melatonin 3mg 1 tab QHS (19 days).
-Cetirizine 10mg 1 tab QHS (19 days).
3/1/25-3/20/25
-Sertraline 25mg 1 tab QD (20 days).
-Atomoxetine 18mg 1 cap QAM (20 days).

FC #4
A. Medications were administered without physician's orders.

Review on 4/10/25 of FC #4's record revealed:
-Date of Admission: 2/14/25.
-Date of Discharge: 2/16/25.
-Diagnoses: Post Traumatic Stress Disorder, chronic; ODD; and ADHD.
-Age: 10 years.
-No physician's orders present.

Review on 4/22/25 of email correspondence sent to the Division of Health Service Regulation (DHSR) surveyors from FC #4's DSS LG dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 53 4/22/25 at 5:35pm revealed: - " ...[FC #4] was brought to facility with his medications. The placement reported he did not have enough medication. SW (Social Worker) (DSS LG) arranged for transfer of medications to placement's (facility's) local pharmacy. Upon his IVC'd (involuntary commitment) admittance to hospital, hospital reported to DSS that the group home reported to them that [FC #4] had not taken any of his medicine and further stated he was not brought with medications which was not true." Review on 4/24/25 of email correspondence sent to DHSR surveyors from FC#4's DSS LG dated 4/24/25 at 10:55am revealed: -"He (FC #4) was on Risperidone, Clonidine and Concerta (Methylphenidate) ...medications were brought and handed to (facility) staff." Review on 4/8/25 and 4/11/25 of FC #4's handwritten MARs dated 2/14/25-2/16/25 revealed the following medications were documented as administered: -Risperidone (antipsychotic) 0.5mg tab 1 tab BID (3 days). -Clonidine (ADHD) 0.1mg 1 tab QHS (2 days). -Methylphenidate (no dosage/route/instructions) (3 days). -Cetirizine 10mg 1 tab QD (3 days). B. MARs were not kept current. Review on 4/11/25 of FC #4's handwritten MARs dated 2/14/25-2/16/25 revealed the following medications were documented as administered: -Methylphenidate, transcription did not include the dose, route, or administration instructions. -Risperidone and Clonidine were initialed as administered on 2/14/25 at 7:00pm but the staff initials which indicated medication administration	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 54 did not correspond to any staff signature on the MAR signature section. Interviews on 4/8/25 and 4/9/25 with the House Manager (HM) revealed: -Wrote the MARs for the facility. -Provided oversight of the MARs and "no one else looked at them." -The Former Associate Professional (FAP) was responsible for making medication appointments for the clients and securing refills. -Acknowledged that Client #1's Sertraline dosage changed in February 2025 from 25mg to 75mg, but the change was not reflected on the MAR. -Could not confirm if Client #1 was administered Ziprasidone 60mg BID February 2025. "Not sure how we missed that, it's not signed off (initialed as administered) ...for the entire month (evening dose)." -"The AP asked staff to come sign (initial to indicate medication administration) the MAR for [Client #1's] Ziprasidone after the previous AP (FAP) left. Nobody else was looking." -"[Former Staff #2 (FS #2)] quit because of the MARs and meds ...and she worked at a hospital." -"His (Client #1's) refills had run out" which is why he was not administered his medications regularly. -"Don't know why staff signed the MAR giving (documenting administration of) his (Client #1's) meds (Qelbree from 3/11/25-3/25/25) when he wasn't getting them ...I know my name was on there too." -The facility contacted a pediatrician to refill Client #1's medication but the pediatrician was not comfortable prescribing Trazodone 100mg QHS. He prescribed Trazodone 50mg QHS. -Client #1 was administered Trazodone 50mg QHS from 3/3/25-3/31/25. -Client #1's MAR reflected he was administered	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 55 Trazodone 100mg QHS from 3/3/25-3/31/25 because "it's written wrong on the MAR ...I didn't write that. I think [FS #2] did. He (Client #1) shouldn't be getting that ...I can't fix it." -Client #1's Trazodone dose was changed back to 100mg QHS at his medication appointment on 3/25/25. -"[Client #1's] Hydroxyzine was PRN but we (staff) gave (administered) it everyday." -Acknowledged that Client #2's Hydroxyzine was ordered as PRN but was not listed as PRN on the March 2025 and April 2025 MARs. -Client #2's Hydroxyzine was administered daily despite the order for PRN administration. -Client #2 was not administered Hydroxyzine from 2/15/25-3/19/25 because the medication had run out and they had to wait to get another appointment. Client #2 went to the medication management appointment on 3/18/25. -Client #2's "behaviors were random." -"Nothing I can say ...about missing signatures." -Did not maintain copies of clients' physicians' orders at the facility. Interviews on 4/8/25 and 4/14/25 with FAP revealed: -Started working for the D/L/QP #2 at the end of January 2025 at sister facility A and resigned from the facility on 3/20/25. -Was responsible for clients' scheduling and taking clients to medical appointments. -Had problems making appointments for the clients because of missing paperwork. The facility did not have Client #1's Medicaid card and Client #2's declaration of custody. The D/L/QP#2 "lost" the paperwork. -Client #1 did not have a provider to prescribe his medications. -Client #1 was not administered his medications for a couple weeks in March 2025 because there	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 56	V 118		

was no prescriber to complete new orders.
-Client #2 missed medications and refused medication a few times but could not identify how often or when.
-The D/L/QP #2 was initially responsible for making sure medications didn't run out, but he assigned her that responsibility in March 2025.
- "As far as missed meds and missing meds, I gave all that to [D/L/QP #2] and I don't have that on me ...I had a huge concern about the clients' meds."
- "I eventually took my hands off and left ...I wasn't going to be liable."

Interview on 4/14/25 with Staff #1 revealed:
-Worked for the D/L/QP #2 since 1/31/25.
-Worked at sister facility A prior to working at the facility.
-The HM provided oversight of clients' medications.
-Client #1 and Client #2 missed medications because when she went to administer the medications, they weren't available and " ...the refills weren't ready for pick up."
-Not sure who was responsible for ensuring medications were present in the facility and available for administration.
-Reported to the FAP that Client #1 was out of medication, and the FAP said "yeah, we know, we were going to get it filled."
-Client #1 appeared "more agitated" when he missed his medication.
-Was unsure if Clients #1 and #2 needed their respective PRNs daily, but they were administered daily.

Interview on 4/14/25 and 4/15/25 with Former Staff (FS) #2 revealed:
-Started working at the facility at the end of January 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 57 -"Quit last week." -Left the facility due to medication issues and D/L/QP #2's approach to overseeing the facility. -Client #1's medications were not administered at times so " ...not sure how the MAR was signed (initialed indicating medication administration). I never saw the signed MAR. I had been working and nobody was signing the MAR. Then, the MAR was signed with other initials (indicating medication administration)." -The pediatrician who saw Client #1 in March 2025 was not comfortable prescribing Client #1's medications because Client #1 wasn't an established patient. -"He (Client #1) could have missed it (medication for ADHD) for more than 2 weeks." -When Client #1's Trazodone was reduced from 100mg to 50mg QHS from 3/3/25-3/25/25 the staff were not aware as " ...[D/L/QP #2] didn't tell staff." -Client #1 was not administered his evening dose of Ziprasidone for February 2025 as prescribed. Was unable to identify why this happened. "I only know that we were waiting on [D/L/QP #2] to talk to [Client #1's] physician." -Was not aware if Client #2 missed medications. -"[D/L/QP#2] was supposed to manage the medications, making sure meds don't run out, get orders, [FAP] started looking at (taking responsibility for) the meds in March (2025)." -"Told [D/L/QP #2] ...that the clients can die ...clients didn't have (were administered) meds ...you can't just do fake signatures (initials indicating administration) on the MAR. He (D/L/QP #2) didn't act like he cared." Interview on 4/15/25 with Former Qualified Professional (FQP) revealed: -Started working at the sister facility A in January 2025 before working at this facility.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 58	V 118		

-Quit working at the facility in the middle of March 2025.
-Was trained in medication administration but did not administer medication.
-She, the FAP, and the D/L/QP #2 were responsible for making sure medications didn't run out.
-Never looked at the client MARs and was unaware of who provided oversight of medications.
-Knew there were issues with Client #1's medications running out but was not sure of what was going on.
-"Not sure why" staff signed the MAR to indicate medication administration when the medications were not administered.
-" ...Didn't check meds, didn't catch that (lack of medication administration)" because she was completing other tasks for the D/L/QP #2.
-Relied on direct care staff to report if client medications were running low.
-"Nobody (was) coming in (to the facility) reviewing the meds and MARs. Let staff know to let us know if (clients were) out of meds, but no follow up if meds run out ...relied on staff."
-"Concerned about the forging of signatures. Me and the former AP had to address forging signatures on MARs with [D/L/QP #2]. I didn't sign a MAR at all."

Interview on 4/15/25 with Former Staff #4 revealed:
-"Never knew who was responsible for reviewing medications."
-"Client #1 ran out of meds 2 or 3 times."
-It was reported to the HM at the time that Client #1's medications were not available for administration.
-Asked the HM about initialing the MAR in (March 2025) and the HM told the anonymous source

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 59 "not worry about it, I'll get it taken care of." -"I didn't want to be a part of the home (facility)." -"It's not safe for the clients there (at the facility)." Interview on 4/15/25 with the AP revealed: -Staff were currently responsible for ensuring medications were in the facility and available for administration. -"It's unacceptable for clients to go weeks without meds." Interview on 4/15/25 with the QP revealed: -The HM should be looking at the MAR everyday making sure it was up to date with initials to indicate medication administration. -The HM was responsible to ensure that the medications were in the facility and available for administration and "I'm sure the AP is looking now." -The HM and AP were responsible for oversight of medications. Interview on 4/16/25 with the facility's dispensing pharmacist revealed: -Client #1's Qelbree 200mg was last dispensed on 12/12/2024 for a 3 month supply and no refills. -Side effects of Client #1 missing Qelbree included hyperactivity, trouble focusing, and difficulty remaining calm. -"If [Client #1] was used to taking Qelbree daily and missed for 2 weeks, withdrawal side effects ...hyperactivity coming back into play ...not as calm ...trouble focusing." -Client #1's reduction in Trazodone dose from 100mg to 50mg QHS may result in him having trouble going to sleep. -Ziprasidone HCl 60mg 1 cap BID was last dispensed on 12/20/24 for a 1 month supply and then on 2/26/24 for a 3 month supply. -Side effects of missing Ziprasidone HCl would	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 60	V 118		

result in an increase in behavioral issues. "The behavioral issues patient (Client #1) had would more than likely re-appear."
-There were no refills on the 12/20/24 prescription for Ziprasidone.
-The last medication dispensed for Client #1 was Trazodone 50mg on 3/5/25 for a 90 day supply with no refills.
-Client #2's Fluoxetine should be administered consistently. It would take a longer time period to see side effects reemerge if he was not administered the medication.
-Side effects for Client #2 missing Dexmethylphenidate included having trouble focusing.

Interview on 4/24/25 with Director/Licensee/QP#2 revealed:
-Worked shifts in the facility as needed.
-Assumed that the FQP and FAP provided oversight of medications and MARs.
-Assumed the FQP and FAP were getting physician orders.
-Did not do any follow up to ensure medications were administered correctly and documented accurately.
- "I assumed when we (staff and himself) talked, that certain things were done ...I didn't really find a lot of things out until the end (of the DHSR survey)."
-The HM was responsible for ensuring medications were available for administration and staff were supposed to tell the HM when medications were low.
-Understood the importance of medication administration.
-Denied he affixed another individual's initials to the MARs to indicate medication administration as he had been accused by his staff.
-Identified that he was responsible for all aspects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 61	V 118		

of the facility's operations. "I'm responsible for everything that has to do with the company ...it's my responsibility ..."
-"What happened was a lot of people got lazy."
-"That's why the nurse is here, we won't have this problem moving forward."
-Acknowledged, currently, the facility did not have a nurse on site checking medications and MARs.
-Denied there were problems securing medical appointments for the clients due to a lack of proper paperwork. "I haven't heard anyone say that to me."
-"All of this was supposed to be done."
-His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done."
-"I was doing what I thought was necessary to run the business."
-"I take full responsibility for the issues, it falls on me, need to have better systems in place."

Review on 4/10/25 of the Plan of Protection (POP) signed by the D/L/QP #2 dated 4/10/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
Medication Management Procedure-H.O.P.E. United Inc. (Licensee)
Step 1: Medication Verification and Documentation
Case management will assist H.O.P.E United Inc. qualified staff by contacting the client's doctor's office to request a copy of the prescribed medication orders. Once received, staff will consult with the agency nurse to review and verify the prescriptions by confirming the correct client and dosage. If there are any discrepancies or concerns, the nurse will immediately contact the prescribing doctor or pharmacy for clarification. The pharmacy will then generate a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 62 computer-based Medication Administration Record (MAR), which staff will retrieve. Step 2: Medication Matching and Administration Upon the client's admission to H.O.P.E. United Inc., the medication will be matched to the following details: -Client's full name -Medication name, Strength, and Quantity -Instructions for Administration -Date and Time of Administration -Signature of Initials of the Administering Staff Any requests for medication changes or evaluations made by the client will be documented and dilled with the MAR, followed up by an appointment or consultation with the physician. Step 3: Secure Storage MARs will be filed and kept in a secure, climate-controlled, and locked area in close proximity to the medication storage. Both medications and MARs are stored in a locked file cabinet and are only accessible to authorized staff. Medications will only be administered to the specific client at the time and dosage prescribed by the physician. Step 4: Oversight and Monitoring Daily: Staff will check and verify MARs and medication logs. Bi-weekly: The nurse, in collaboration with the Qualified Professional (QP) or house manager/Associate Professional (AP), will conduct routine reviews to ensure accurate medication administration. In the event of a medication error or emergency (e.g., missed dose, wrong dosage, missing medication), staff must immediately notify the nurse. The nurse will then contact the doctor's office or pharmacy to resolve the issue. A detailed report of the incident will be written by the nurse and submitted via the IRIS (Incident Response Improvement System) system within 24 hours.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 63 Step 5: Medication Disposal When medication needs to be discarded, the House Manager/AP one additional staff member must complete a disposal form (type or handwritten) containing: -Name of the Medication -Strength and Quantity -Date and Method of Disposal -Signature of both the Disposer and Witness Step 6: Monthly Medication Disposal When medication needs to be discarded, the House manager/AP and one additional staff member must complete a disposal form (typed or handwritten) containing: -Name of the medication -Strength and Quantity -Date and method of Disposal -Signature of both the Disposer and Witness Step 6: Monthly Medication Review Each month, the nurse will meet with the client in a private setting to review their medications. The nurse will discuss the effectiveness, side effects, and the client's overall response to the medication. If any issues or concerns arise, the nurse will follow up with the prescribing doctor with or without the client present, based on the situation. Describe your plans to make sure the above happens. To ensure the above corrective actions are followed and adhered to the House Manager/AP along with another staff will do the following either handwritten or typed include the following: Name of the Medication, Strength, Quantity, disposal date and method, the signature of the person disposing the medication and the person witnessing the destruction of the medication. The nurse along with the Qualified Professional will have 24 hours to write incident report with the Iris system. Every month the nurse will call the client	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 118	Continued From page 64 in secure location and discuss the medication they are taking and discuss the action of the meds. She will also ask how they perform, are they feeling on the medication and do they need adjustments. If there are any concerns the nurse will contact the doctor's office and discuss the patients health either with or without the client present." Review on 4/11/25 of the amended POP signed by the D/L/QP #2 dated 4/10/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Hope united Inc. initiated the process to obtain all doctors orders and scripts for the consumers and has obtained all scripts and Physician orders for the consumers. These orders will be housed in the consumers' files/chart along with their MARS in a locked cabinet in the home. The owner of Hope United LLC, will be responsible for reviewing the prescriptions and matching the meds and the MAR, contacting the pharmacy, and matching the physician order to the medications effective immediately, 4/10/2025 until a RN is hired. Hope United Inc. will hire and retain a RN by 4/21/2025, who will provide services weekly or biweekly to monitor the consumers by signing necessary documents that will include the consumers' clinical services while in the program, track progress and goals, ensure medication compliance and provide staff monitoring when they are administering medications. The facility RN will call the physician to obtain orders and scripts as medications are prescribed as well as provide weekly supervision and maintenance to ensure the meds and the MARS are matched and dispensed properly. Describe your plans to make sure the above happens. Medication Management Procedure-H.O.P.E.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 65 United Inc. Step 1: Medication Verification and Documentation The RN will be responsible for contacting the consumer's doctor's office to request a copy of the prescribed medication orders. Once received, staff will consult with the agency RN to review and verify the prescriptions by confirming the correct client and dosage. If there are any discrepancies or concerns, the RN will immediately contact the prescribing doctor or pharmacy for clarification. Step 2: Medication Matching and Administration Upon the client's admission to H.O.P.E. United Inc., the RN will match the following details: Daily: During visits, the RN will ensure medications match doctors offers and scripts, checking the dates and making sure they are not expired, making sure refills are being sent in timely. In the event of a medication error or emergency (e.g., missed dose, wrong dosage, missing medication), staff must immediately notify the RN. The RN will then contact the doctor's office or pharmacy to resolve the issue. Step 6: Bi-weekly Medication Review Before administering any new medication(s) and to ensure compliance with medication administration with current medication, the RN, will conduct routine reviews bi-weekly to ensure accurate medication administration (checking correct medication, correct dosage, and correct frequency). Each month, the RN will meet with the consumer in a private setting to review their medications. The RN will discuss the effectiveness, side effects, and the Consumer's overall response to the medication. If any issues or concerns." Review on 4/15/25 of the 3rd amended POP signed by the D/L/QP #2 dated 4/15/25 revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 66 -"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens. Bi Weekly: During visit, the RN will ensure medications match doctors offers and scripts, checking the dates..." Review on 4/30/25 of the undated, unsigned 4th amended plan of protection submitted on 4/30/25 by the D/L/QP #2 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens. "Verify Guardian's Authority: Confirm that the individual is the legal guardian and has the authority to administer medication. This may involve checking court documents or guardianship orders. Provide Medication Details: Share clear instructions about the medication, including: Name of the medication. Dosage and frequency. Administration method (e.g. (exempli gratia), oral, injection). Any special instructions (e.g., take with food). Document Handover: Maintain a record of the medication transfer, including: Date and time of handover. Quantity of medication provided. Guardian's signature acknowledging receipt. Educate the Guardian: Ensure the guardian understands: How to administer the medication correctly. Potential side effects and what to do in case of an adverse reaction. Storage requirements (e.g., refrigeration). Provide Contact Information: Offer a way to reach the prescribing practitioner or facility staff for	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 67	V 118		

questions or emergencies.
Here's a draft template for documenting the medication handover and providing instructions for the legal guardian:

_____
Medication Handover Record
Client's Name: _____Legal Guardian's Name: _____ Date of Handover: _____ Time of Handover: _____ Medication Details:
Name: _____
Dosage: _____
Frequency: _____
Route of Administration (e.g., oral, injection): _____
Quantity Provided: _____
Special Instructions: _____
Guardian's Statement of Receipt:
I, _____ (Guardian's Name), acknowledge receipt of the above-listed medication (s) for administration to _____ (Client's Name). I have been educated on how to administer the medication (s), the potential side effects, and storage requirements.
Guardian's Signature: _____ Staff Member's Name: _____ Staff Member's Signature:
_____
_____
Instructions for Legal Guardian
Medication Administration:
Administer as per the prescribed dosage and schedule.
Ensure proper hygiene while administering medication (e.g., washing hands).
Storage:
Store the medication according to the provided instructions (e.g., refrigerated or kept in a cool,

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 68	V 118		

dry place).
Keep the medication out of reach of unauthorized individuals or children.
Side Effects:
Monitor for any adverse effects listed in the instructions.
Contact the prescribing practitioner or facility immediately if side effects occur.
Emergency Contact:
Facility/Staff Contact: _____
Prescribing Practitioner: _____
Return of Medication (if applicable):
Return any unused medication upon the client's return to the facility."

Review on 4/30/25 of the undated, unsigned, 5th amended plan of protection submitted by the D/L/QP #2 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Prior to consumer leaving the facility the qualified professional, director or designated staff will contact the pharmacy. Staff will explain that a consumer is leaving the facility for a designated period of time which will be explain to the pharmacist. The direct care staff take the medication to the pharmacy and have them package up the necessary medication for the allotted time specified. Once the consumers legal guardian arrive the following will happen. There will be a written form that will need to be filled out with the following information and that form will be kept in H.O.P.E. United, Inc (incorporated) files. Describe your plans to make sure the above happens."

Review on 4/30/25 of the 6th amended plan of protection dated 4/30/25, signed and submitted by the D/L/QP #2 revealed:
-There was nothing different than the 5th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 69	V 118		

amended plan of protection submitted by the D/L/QP #2.

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

This facility served adolescents aged 9 through 17 with diagnoses including the following: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Unspecified Trauma and Stressor Related Disorder, Major Depressive Disorder, Enuresis, Encopresis, Bipolar Disorder, and Post Traumatic Stress Disorder.
Medications were administered to Clients #1, #2, FC #3, and FC#4 without the order of a physician. Client MARS were not kept current and did not match what physician orders were present in the facility. Client #1 missed up to 40 total doses of medications from 2/14/25-4/8/25. These medications included 14 days (doses) of Qelbree (ADHD), 12 days (doses) of Sertraline (depression) and 14 days (doses) of Ziprasidone (antipsychotic). Facility staff documented administration of Hydroxyzine 25mg tab (anxiety), to Client#1 BID routinely, but it was ordered for PRN use. There was documentation of administration of Hydroxyzine 10mg tab to Client #2 routinely every night, instead of the ordered PRN use. Client #2 missed 2 days of Dexmethylphenidate (ADHD) and 2 days (doses) of Fluoxetine (depression) from 2/14/25-4/8/25. There was no oversight of medications and MARs after the HM's review. There was documentation on the MAR that medications were administered when they weren't for Client #1 and #2 including 26 of the 40 missed doses of medication for Client #1. There was no

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 118	Continued From page 70 correspondence with Client #1 and Client #2's guardian, care coordinators, or physician/pharmacist when there were medication errors. The facility also failed to ensure that Client #1 retained a prescribing provider to avoid a lapse in sleep medication resulting in 50mg decrease in dosage (Trazodone) for approximately 22 days. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to ensure that all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 2 clients (#1 and #2). The findings are:	V 123		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 123	Continued From page 71 Review on 4/8/25 of Client #1's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression. -Age: 17 years. -Physician's orders dated 3/25/25: -Qelbree ER (extended release) 200 milligrams (mg) (ADHD) 2 capsules (caps) every morning (QAM). -No physician orders for: -Sertraline 25mg (depression) 1 tablet (tab) daily (QD). -Sertraline 25mg 3 tabs QD. -Ziprasidone HCl (hydrochloride) 60mg (anti-psychotic) 1 cap twice daily (BID). Review on 4/11/25 of a list of Client #1's medications dispensed from a local pharmacy revealed: -Qelbree ER 200mg dispensed 12/11/24, quantity (qty) 180 (90 days). -Sertraline 25mg dispensed 12/18/24, qty 30 (30 days). -Sertraline 25mg dispensed 2/26/25, qty 270 (90 days). -Ziprasidone HCL 60mg dispensed 12/18/24, qty 60 (30 days). -Ziprasidone HCL 60mg dispensed 2/26/25, qty 180 (90 days). Observation on 4/8/25 at approximately 10:30am of Client #1's medications revealed: -Qelbree ER 200mg dispensed 3/25/25, qty 60 (30 days). Review on 4/8/25 and 4/11/25 of Client #1's handwritten Medication Administration Records (MARs) dated 2/14/25 to 4/8/25 revealed the following medications were administered daily:	V 123		

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 123	Continued From page 72 -Qelbree ER 200mg 2 capsules. -Sertraline 25mg on 2/14/25-3/1/25. -Sertraline 25mg 3 tabs on 3/1/25-4/8/25. -Ziprasidone HCL 60mg 2 capsules. Interview on 4/9/25 with Client #1 revealed: - "Went without my meds (medications) for about a month, almost all of them ...I felt horrible ...agitated." Interview on 4/16/25 with Client #1's Mother/Legal Guardian revealed: -Was not aware if there had been any medication changes for Client #1, "hadn't heard anything." -No one from the facility reported that Client #1 had missed any medication. Review of Client #2's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -Physician's order dated 3/18/25 for: -Dexmethylphenidate 15mg (ADHD) 1 cap QAM. Review on 4/11/25 of a list of Client #2's medications dispensed from a local pharmacy revealed: -Dexmethylphenidate ER 15mg dispensed 2/14/25, qty 30 (30 days). Observation on 4/8/25 at approximately 10:40am of Client #2's medications revealed: -Dexmethylphenidate ER 15mg dispensed 3/18/25, qty 30 (30 days). Review on 4/8/25 and 4/11/25 of Client #1's handwritten MARs dated 2/14/25 to 4/8/25	V 123		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 123	Continued From page 73 revealed the following medications were administered daily: -Dexmethylphenidate ER 15mg. Interview on 4/9/25 with Client #2 revealed: - "I missed meds sometimes because they (facility) didn't have the refills, don't know which ones...the morning take 2 pills, at night take 3 pills, so I know if it is off ..." Interview on 4/16/25 with Client #2's Department of Social Services Legal Guardian revealed: - "Wasn't aware he missed medications; nobody is telling me about med errors." Review on 4/8/25 of facility incident reports from 2/14/25-4/8/25 revealed: -No incident reports regarding medication administration errors. Review on 4/7/25-4/30/25 of facility records revealed: -No documentation of contact with a pharmacist or physician for medication errors. Interview on 4/16/25 with the dispensing pharmacist revealed: -No reports of medication errors from the facility. Interview on 4/9/25 with the House Manager (HM) revealed: -Provided oversight of the medication administration records and the medications. -The Former Associate Professional (FAP) was responsible for completing incident reports. -Did not know if there were any completed incident reports regarding medication administration as she "never saw it..." -Did not contact a pharmacy or physician regarding medication errors.	V 123		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 123	Continued From page 74 Interview on 4/15/25 with Former Staff #2 (FS #2) revealed: "I left (the facility) because I pointed out a med error...and [Director/Licensee/QP #2's] response was he'll just sign whatever, told him I was not going to do that...unsafe for the clients, that's not fair for the staff, forged staff signature isn't right...didn't think that was right so I left immediately." Interviews on 4/14/25 and 4/15/25 with the FAP revealed: -The "Former Qualified Professional (FQP) took charge and did the (incident) reports" about medication errors. Interview on 4/15/25 with the FQP revealed: -Instructed staff to document medication errors, including medication refusals, and to notify staff if clients were out of meds. - " ...if it was done or not, not sure." - "Probably things missed, not intentionally, but several things not done that we were trying to get done." Interview on 4/15/25 with the AP revealed: -There was currently no medication error reporting system for staff to implement. -Would work to get a system in place to address medication errors with the facility's Registered Nurse and QP #1. -Staff on shift provided oversight of medication. Interview on 4/15/25 with the QP #1 revealed: -HM provided oversight of medications. -Knew how to train staff "now" on reporting medication administration errors. - "Med errors ... should be reported by calling HM and nurse, letting know med error, write on back	V 123		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 123	Continued From page 75 of MAR med that was missed in red ink, circle date med was missed ...trained to call the nurse and let them know." -Did not include reporting medication errors to a pharmacist or physician when he identified the protocol for handling a medication error. Interviews on 4/24/25 and 4/29/25 with the D/L/QP #2 revealed: -Supervised the QP, AP, FQP, FAP, and direct care staff including the HM. -Responsible for "everything" with the facility. -Acknowledged the facility did not have any incident reports or documentation regarding medication errors. -The HM and staff were responsible for reporting medication errors. - "Thought it was being done, don't understand why a medication not given, don't understand how staff missed that." -"If you don't give (administer) a med, you can't say you did." -Did not follow up behind the FQP/FAP for medication errors. -Did not know that medication errors needed to be immediately reported to a pharmacist or physician and documented. -Instructed staff to contact the AP, complete an incident report, and then contact the pharmacist or physician for medication errors last. -Had identified a Registered Nurse to hire to assist the facility with medication oversight; however, she was still completing required training and had not yet started work for the facility. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 violation and must be corrected within 23 days.	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to an offer of employment affecting 1 of 5 staff (House Manager (HM)). The findings are: Review on 4/8/25 of the HM's record revealed: -Hire date: 8/2/24. -HCPR accessed: 8/7/24. Interview on 4/8/25 with the Director/Licensee/ Qualified Professional #2 revealed: -Was responsible for accessing the HCPR for newly hired staff. -HCPR check for the HM was completed after an offer of employment but prior to her working in the facility with the clients. -"Thought that as long as it (HCPR) was done before they (staff) start working with the kids (clients), that it is okay." -"Hired her (HM) 8/2/24 but didn't start working (in the facility) until later, but now I know (the rule	V 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 131	Continued From page 77 required that HCPR was accessed prior to an offer of employment)."	V 131		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 78 acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to provide intensive, active therapeutic treatment and interventions which included supervision and structure of daily living, minimizing the occurrence of behaviors related to functional deficits, ensuring safety and deescalating out of control behaviors, assisting the adolescent in the acquisition of adaptive functioning in self-control, communication, and social skills, supporting the adolescent in gaining the skills needed to step-down to a less intensive treatment setting, and coordinate with other individuals within the child or adolescent's system of care affecting 2 of 2 current clients (#1 and #2) and 2 of 2 former clients (FC #3 and FC #4). The findings are: Cross Reference: 10A NCAC 27G .0201 Personnel Requirements (V108). 10A NCAC 27G	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 79 .0201 Personnel requirements (V108). Based on record review and interview, the facility failed to provide training to meet the MH/DD/SAS needs of the clients affecting 3 of 5 current staff (Staff #1, House Manager (HM), and Associate Professional (AP)) and 4 of 5 former staff (Former Staff (FS) #2, FS #3, FS #4, and Former AP (FAP)). Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview, 3 of 3 qualified professionals (Qualified Professional (QP) #1, Former QP (FQP), and Director/Licensee/QP #2 (D/L/QP #2)) failed to demonstrate the knowledge, skills, and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to ensure admission assessments were completed prior to the delivery of services affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3). Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interview, the facility failed to ensure treatment strategies were developed, current and implemented to address clients' needs affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3). Cross Reference: 10A NCAC 27G .0206 Client Records (V113). Based on record review and interview, the facility failed to maintain the required documentation in the client's record	V 293		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 80 affecting 2 of 2 current clients (#1 and #2) and 2 of 2 former clients (FC #3 and FC #4). Cross Reference: 10A NCAC 27G .1702 Requirements of Qualified Professionals (V294). Based on record review and interview, the facility failed to ensure Qualified Professionals performed clinical and administrative responsibilities a minimum of 10 hours each week with 70% of the time when clients were awake and present in the facility and failed to ensure the supervision of the Associate Professional (AP), oversight of emergencies, provision of direct psychoeducational services, participation and coordination of treatment plans, and provision of case management functions. Cross Reference: 10A NCAC 27G .1703 Requirements for Associate Professionals (V295). Based on record review and interview, the facility failed to employ a full-time AP who ensured management of the daily operations of the facility, supervision of paraprofessionals, and participation in service planning meetings. Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on observation, record review, and interview, the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. Cross Reference: 10A NCAC 27G .1705 Requirements of Licensed Professionals (V297). Based on record review and interview, the facility failed to employ a Licensed Professional (LP) to ensure clinical supervision, therapy services, and participation in treatment plans or overall programmatic issues. Cross Reference: GS 122C-62 Additional rights in	V 293		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 81 24-hour facilities (V364). Based on record review and interview, the facility failed to ensure client rights in a 24 hour facility affecting 2 of 2 clients (#1 and #2). Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements For Category A and B Providers (V366). Based on record review and interview, the facility failed to implement policies governing their reporting and response to level I and II incidents as required. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements For Category A and B Providers (V367). Based on record review and interview, the facility failed to report all Level II incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incidents. Cross Reference: 10A NCAC 27E .0101 Least Restrictive Alternative (V513). Based on record review and interview, the facility did not promote a respectful environment using the least restrictive and most appropriate settings and methods affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3). Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536). Based on record review and interview, the facility failed to ensure 1 of 5 current staff (Staff #1) and 5 of 5 former staff (FS #2, FS #3, FS #4, the FAP, and the FQP received initial training in alternatives to restrictive interventions. Interviews on 4/9/25 and 4/24/25 with Client #1 revealed: -Was "not on a schedule" to see a therapist.	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 82 -"...saw one (therapist) a couple weeks ago (prior to 4/9/25), don't know name." -Therapists don't come to the facility. -Had "no group therapy" in the facility. -Did not receive substance use therapy or attend 12 step meetings as identified in his treatment plan. -Had not visited with a therapist from 4/9/25-4/24/25, "don't know why not...been about a month since I saw a therapist." -"Helpful to have someone else to talk to (therapist) other than the staff in the home (facility)." Interviews on 4/16/25 and 4/23/25 with Client #1's Mother/Legal Guardian revealed: -She did not find out Client #1 was suspended from school the week of 4/10/25 until the Child Family Team (CFT) meeting on 4/10/25 at 1pm, "nobody called me." -Client #1 had a new therapist (LP), "don't know what happen with last therapist (LP) (as of 4/23/25)." -"...don't know if they (previous therapist) dropped him (Client #1) or what, (facility staff) didn't tell me none of that." -Client #1 did not receive any therapy services related to his substance use at the facility. -"Nobody talked to me about continuing substance use therapy for Lakeview (facility)." Interview on 4/14/25 with the FAP revealed: -Prior to March 2025 "him (Client #2) and [Client #1] were missing appointments (therapy)...wasn't bi-weekly, no schedule." Interview on 4/15/25 with the FQP revealed: -The facility did not employ an LP an "...no therapists came to the home (facility)..." -The client's did not receive therapy	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 83	V 293		

"consistently."
-The clients missed scheduled therapy appointments due to staff not taking them.
-"[Client #1] was supposed to go (to therapy) weekly, but staff wasn't getting him there weekly, [Client #2] missing appointments as well."
-There were no follow up with staff about the missed therapy appointments other than the FAP and the FQP informing staff to reschedule the therapy appointment and confirm the clients went.
-"Hard to take clients to appointments with one staff on shift, think staffing may have been the issue why appointments (therapy) were missed."

Interview on 4/8/25, 4/24/25 and 4/28/25 with the D/L/QP #2 revealed:
-There was "no LP assigned (employed) for the facility...no assigned LP providing clinical oversight (of the facility) as of now."
-Was "under the impression FQP and FAP were making therapy appointments."
-"Myself, [the HM] or [the AP]" were responsible for coordinating therapy services for the clients.
-"Normally [the HM] makes the calls for appointments (schedule therapy)."
-Was unable to confirm if Client #1 received therapy prior to his Comprehensive Clinical Assessment dated 3/26/25, "...trying to implement more therapy now...not sure who therapist is...would have to ask [HM] who they are."
-Client #1 was not going to substance use group 3 times per week as said in 3/26/25/ treatment plan.
-Client #2 had missed therapy appointments but don't think it was many."
-"Therapist haven't been coming to the facility."
-There was "previously no oversight over [the FQP]."
-His role in the facility was to "put eyes on everything that is supposed to be done and if not

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 84 put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." Review on 4/10/25 of the Plan of Protection (POP) completed by the D/L/QP #2 dated 4/10/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure an effective Administrative Action plan is being adhered to, Hope United Inc. (Licensee) intends to provide continuing education for current and future staff including but not limited to: Qualified Professionals, House Managers, Associate Professionals, and any direct support staff. Hope United Inc. will continue to maintain the required staff ratio of 2 staff per shift to effectively provide services to the consumers and ensure safety and healthy living. Hope United Inc. will thoroughly screen all current and potential staff ensuring they are in compliance with trainings, current credentials, and have no criminal or unlawful occurrences. Hope United Inc. will hire and retain a Licensed Nurse, Licensed Professional (Licensed Clinical Social Worker (LCSW)), and a Medical Practitioner who will provide services weekly or biweekly to monitor the consumers by continuity of care, track progress and goals, ensure medication compliance and provide staff monitoring, and complete assessments such as initial Admission Assessments and CCA's (Comprehensive Clinical Assessment). The safety of the consumers is very important to Hope United Inc. and the processes we use to maintain their safety. A descriptive Disciplinary Action Plan will	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 85	V 293		

be initiated immediately to provide a safe and healthy environment for our consumers. An update to house rules and expectations of the staff and consumers with the assistance of staff will create and follow a daily schedule/routine to ensure organization and structure, and to ensure goals and interventions included on the consumers PCP (Person Centered Plan) are being executed. The QP will monitor and update the plans quarterly, monitor staff engagement, and ensure the plan is effective and progress is being made. Staff at Hope United Inc. will maintain documentation daily and make sure all administrative tasks are completed timely. A thorough review of the documentation will be completed by the QP 2 times a week. The QP will hold all staff accountable for their mistakes and corrections and ensure documentation is in compliance and showing effectiveness.
Describe your plans to make sure the above happens.
Hope United Inc. management team and staff will complete mandatory meetings weekly to keep staff informed of operational and structural changes in the company and group home. Ultimately, reducing the mandatory meetings to once a month. Hope United Inc. management will put company policies in place for staff to abide by and enforce these policies as stipulated in the policy. Staff will need to sign the policy and uphold their duties as stipulated in the policy, their job descriptions, and employee manual. Hope United Inc. HR (Human Resources) will secure a recruitment team that will frequently follow up on potential new hires who are competent, experienced, and physically able to carry out their job responsibilities with knowledge and confidence. Hope United Inc. will secure additional assistance such as consulting services, routine trainings (CPR (cardiopulmonary

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 86	V 293		

resuscitation)/First Aid, Medication Training, Client Specific Training, etc), and schedule review of state regulations and MCO's policies and procedures that may have been added or updated."

Review on 4/11/25 of the 2nd POP completed by the D/L/QP #2 dated 4/10/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure an effective Administrative Action plan is being adhered to, Hope United Inc. intends to provide continuing education for current and future staff including but not limited to: Qualified Professionals, House Managers, Associate Professionals, and any direct support staff. Hope United Inc. will thoroughly screen all current and potential staff ensuring they are in compliance with trainings, current credentials, and have no criminal or unlawful occurrences. Hope United Inc. will continue to maintain the required staff ratio of 2 staff per shift to effectively provide services to the consumers and ensure safety and healthy living. Hope United Inc. will meet minimum staffing requirements as of 4/11/25. Hope United Inc. will hire and retain a Licensed Nurse, Licensed Professional (LCSW), and a Medical Practitioner who will provide services weekly or biweekly to monitor the consumers by providing therapeutic services, sign necessary documents that will include the consumers continuity of care, track progress and goals, ensure medication compliance and provide staff monitoring, and complete assessments such as Initial Admission Assessments and CCA's. In the meantime, therapeutic services as well as medical/clinical supports will be maintained by a third party company, Preferred Choice in Rutherfordton, NC and Foothills Psychology in Shelby, NC. Hope united Inc. owner is currently in

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 87 the process of interviewing candidates for a Licensed Nurse, Licensed Professional and Medical Practitioner. All open positions will be filled no later than 4/21/25. The safety of the consumers is very important to Hope United Inc. and the processes we use to maintain their safety. A descriptive Disciplinary Action Plan will be initiated immediately to provide a safe and healthy environment for our consumers. An update to house rules and expectations of the staff and consumer will be completed and posted for all residents and staff to see and follow daily. The consumers with the assistance of staff will create and follow a daily schedule/routine to ensure organization and structure, and to ensure goals and interventions included on the consumers PCP are being executed. The QP will monitor and update the plans quarterly, monitor staff engagement, and ensure the plan is effective and progress is being made. Staff at Hope United Inc. will maintain documentation daily and make sure all administrative tasks are completed timely. A thorough review of the documentation will be completed by the QP 2 times a week. The QP will hold all staff accountable for their mistakes and corrections and ensure documentation is in compliance and showing effectiveness. Describe your plans to make sure the above happens. Hope United Inc. management team and staff will complete mandatory meetings weekly to keep staff informed of operational and structural changes in the company and group home. Ultimately, reducing the mandatory meetings to once a month. Hope United Inc. management will put company policies in place for staff to abide by and enforce these policies as stipulated in the policy. Staff will need to sign the policy and uphold their duties as stipulated in the policy, their	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 88	V 293		

job descriptions, and employee manual. Hope United Inc. HR will secure a recruitment team that will frequently follow up on potential new hires who are competent, experienced, and physically able to carry out their job responsibilities with knowledge and confidence. Hope United Inc. will secure additional assistance such as consulting services, routine trainings (CPR/First Aid, Medication Training, Client Specific Training, etc), and schedule reviews of state regulations and MCO's policies and procedures that may have been added or updated.

Review on 4/15/25 of the 3rd POP completed by the D/L/QP #2 dated 4/15/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure an effective Administrative Action plan is being adhered to, Hope United Inc. intends to provide continuing education for current and future staff including but not limited to: Qualified Professionals, House Managers, and any direct support staff. Hope United Inc. will thoroughly screen all current and potential staff ensuring they are in compliance with trainings, current credentials, and have no criminal or unlawful occurrences. Staff at Hope United Inc. will maintain documentation daily and make sure all administrative tasks are completed timely. Hope United Inc. will continue to maintain the required staff ratio of 2 staff per shift to effectively provide services to the consumers and ensure safety and healthy living. Hope United Inc. will meet minimum staffing requirements as of 4/11/25. Hope United Inc. will hire and retain a Licensed Practical Nurse (RN (registered nurse)) initially but may retain a Licensed Registered Nurse (RN) thereafter who will come into the facility weekly or biweekly to monitor Medication Administration Records, ensure medication compliance of the

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 89	V 293		

consumers, and discuss medication requirements with other medical professionals (Doctors, Nurse, and or hospital personnel). Also have weekly meetings via phone or in person with the QP, and RN to discuss the medical needs and health of the consumers on behalf of the consumer. Therapeutic services are currently being maintained by [outside therapy services] in [nearby city] and [private psychology office] in [nearby city], two third party companies who will provide medical/clinical supports such as, signing necessary documents that will include the consumers' clinical services while in the program, track consumers progress and goals, reviewing pertinent documents and completing CCA amendments. Hope united Inc. is retaining a Licensed Professional Therapist (LCSW), who will provide a minimum of 4 hours weekly to consumers in the facility face to face while will provide therapeutic services, sign necessary documents that will include the consumers' clinical services while in the program, track consumers progress and goals, and complete assessments such as Initial Admission Assessments and CCA's. Hope United Inc. owner is currently in the process of interviewing candidates for a RN, licensed professional Therapist (LCSW) and Medical Practitioner. All open positions will be filled no later than 4/21/2025. The safety of the consumers is very important to Hope United Inc. and the processes we use to maintain their safety. A descriptive Interdisciplinary Action Plan will be initiated immediately to provide a safe and healthy environment for our consumers. An update to house rules and expectations of the staff and consumer will be completed and posted for all residents and staff to see and follow daily. The consumers with the assistance of staff will create and follow a daily schedule/routine to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 90 organization and structure, and to ensure goals and interventions included on the consumers PCP are being executed. Effective 4/14/2025, the QP will work 10 hrs weekly and responsibilities will include: developing goals and PCP's for consumers and ensure goals are being implemented correctly by direct support staff. The QP will monitor and update the plans quarterly, monitor staff engagement, and ensure the plan is effective and progress is being made. A thorough review of the documentation will be completed by the QP 2 times a week. The QP will hold all staff accountable for their mistakes and corrections and ensure documentation is in compliance and showing effectiveness. Describe your plans to make sure the above happens. Starting 4/14/2025, Hope United Inc. management team and staff will complete mandatory meetings weekly to keep staff informed of operational and structural changes in the company and group home. Ultimately, reducing the mandatory meetings to once a month. Hope United Inc. management has updated and implemented house rules and company policies for staff to abide by and will enforce these policies as stipulated. Staff will need to sign the policy and uphold their duties as stipulated in the policy, their job descriptions, and employee manual. Hope United Inc. management will frequently follow up on potential new hires who are competent, experienced, and physically able to carry out their job responsibilities with knowledge and confidence. Hope United Inc. will secure additional assistance such as consulting services, routine trainings (CPR/First Aid, Medication Training, Client Specific Training, etc), and schedule reviews of state regulations and MCO's policies and procedures that may have been added or updated. All aspects of this plan of	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 91	V 293		

protection and continuing education for the staff will begin 4/14/2025 in which they will participate in and complete all state mandated trainings and remain in compliance annually or when training renewals are due."

Review on 4/16/25 of the 4th POP completed by the D/L/QP #2 dated 4/15/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? To ensure an effective Administrative Action plan is being adhered to, Hope United Inc. intends to provide continuing education for current and future staff including but not limited to: Qualified Professionals, House Managers, and any direct support staff. Hope United Inc. will thoroughly screen all current and potential staff ensuring they are in compliance with trainings, current credentials, and have no criminal or unlawful occurrences. Staff at Hope United Inc. will maintain documentation daily and make sure all administrative tasks are completed timely. Hope United Inc. will continue to maintain the required staff ratio of 2 staff per shift to effectively provide services to the consumers and ensure safety and healthy living. Hope United Inc. will meet minimum staffing requirements as of 4/11/25. Hope United Inc. will hire and retain a Licensed Practical Nurse (RN) initially but may retain a Licensed Registered Nurse (RN) thereafter who will come into the facility weekly or biweekly to monitor Medication Administration Records, ensure medication compliance of the consumers, and discuss medication requirements with other medical professionals (Doctors, Nurse, and or hospital personnel). Also have weekly meetings via phone or in person with the QP, and RN to discuss the medical needs and health of the consumers on behalf of the consumer. Therapeutic services are currently being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 92 maintained by Preferred Choice in Rutherfordton, NC and Foothill Psychology in Shelby, NC, two third party companies who will provide medical/clinical supports such as, signing necessary documents that will include the consumers' clinical services while in the program, track consumers progress and goals, reviewing pertinent documents and completing CCA amendments. Hope united Inc. is retaining a Licensed Professional Therapist (LCSW), who will provide a minimum of 4 hours weekly to consumers in the facility face to face while will provide therapeutic services, sign necessary documents that will include the consumers' clinical services while in the program, track consumers progress and goals, and complete assessments such as Initial Admission Assessments and CCA's. Hope United Inc. owner is currently in the process of interviewing candidates for a RN, Licensed Professional Therapist (LCSW) and Medical Practitioner. All open positions will be filled no later than 4/21/2025. The safety of the consumers is very important to Hope United Inc. and the processes we use to maintain their safety. A descriptive Interdisciplinary Action Plan will be initiated immediately to provide a safe and healthy environment for our consumers. An update to house rules and expectations of the staff and consumer will be completed and posted for all residents and staff to see and follow daily. The consumers with the assistance of staff will create and follow a daily schedule/routine to ensure organization and structure, and to ensure goals and interventions included on the consumers PCP are being executed. Effective 4/14/2025, the QP will work 10 hrs (hours) weekly and responsibilities will include: developing goals and PCP's for consumers and ensure goals are being implemented correctly by direct support staff. The	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 93 QP will monitor and update the plans quarterly, monitor staff engagement, and ensure the plan is effective and progress is being made. A thorough review of the documentation will be completed by the QP 2 times a week. The QP will hold all staff accountable for their mistakes and corrections and ensure documentation is in compliance and showing effectiveness. Effective 4/22/2025 a Associate Professional (AP) will work full time as a direct care staff. They may work various shift to learn the behaviors of consumers. Management day to day operation of the facility. Supervision of the Paraprofessional regarding responsibilities related to implication of consumers. AP will participate in-service plan meeting. Describe your plans to make sure the above happens. Starting 4/14/2025, Hope United Inc. management team and staff will complete mandatory meetings weekly to keep staff informed of operational and structural changes in the company and group home. Ultimately, reducing the mandatory meetings to once a month. Hope United Inc. management has updated and implemented house rules and company policies for staff to abide by and will enforce these policies as stipulated. Staff will need to sign the policy and uphold their duties as stipulated in the policy, their job descriptions, and employee manual. Hope United Inc. management will frequently follow up on potential new hires who are competent, experienced, and physically able to carry out their job responsibilities with knowledge and confidence. Hope United Inc. will secure additional assistance such as consulting services, routine trainings (CPR/First Aid, Medication Training, Client Specific Training, etc), and schedule reviews of state regulations and MCO's policies and procedures that may have been added or updated. All aspects of this plan of	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 94	V 293		

protection and continuing education for the staff will begin 4/14/2025 in which they will participate in and complete all state mandated trainings and remain in compliance annually or when training renewals are due."

Review on 4/30/25 of an addendum to the 4th POP completed by the Director/Licensee/QP #2 dated 4/30/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? The Director with the assistance of the qualified professional will ensure that the following will be met."

Review on 4/30/25 of an email titled "LEAST RESTRICTIVE" sent by the D/L/QP #2 on 4/30/25 in response to the request of a POP revealed:
-"Standard Operating Procedure (SOP)
Title: Holistic Approach to Restrictive Intervention
Reference: 10A NCAC 27E .0101 & 10A NCAC 27G .1701

Purpose:
To ensure the use of restrictive interventions aligns with the principles of least restrictive alternatives while promoting a holistic approach that respects the dignity, rights, and well-being of individuals.

Scope:
This SOP applies to all staff involved in the implementation of restrictive interventions within the facility, as outlined in 10A NCAC 27E .0101 and 10A NCAC 27G .1701.

Policy Statement:
Restrictive interventions shall only be employed as a last resort and must be accompanied by actions that ensure dignity, respect, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 95	V 293		

promotion of coping and engagement skills. A holistic approach will be utilized to address the underlying causes of behaviors and foster meaningful engagement.

Procedures:

Assessment and Planning:

Conduct a comprehensive assessment of the individual's needs, preferences, and triggers.
Develop a personalized intervention plan that prioritizes non-restrictive alternatives.

Implementation of Least Restrictive Alternatives:

Utilize strategies such as positive reinforcement, de-escalation techniques, and therapeutic engagement.
Ensure interventions are tailored to the individual's unique circumstances and are culturally sensitive.

Restrictive Intervention Protocol:

Restrictive interventions may only be used when all other alternatives have been exhausted and there is an imminent risk of harm.
Obtain authorization from a qualified professional before implementing any restrictive intervention.
Ensure interventions are carried out by trained personnel in a safe and respectful manner.

Monitoring and Documentation:

Continuously monitor the individual's response to the intervention and adjust the approach as needed.
Document all interventions, including the rationale, methods used, and outcomes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 96 Post-Intervention Support: Provide support to the individual to address any emotional or physical impacts of the intervention. Engage the individual in discussions to identify alternative coping strategies for the future. Training and Education: Conduct regular training sessions for staff on holistic approaches, least restrictive alternatives, and intervention techniques. Promote awareness of the principles outlined in 10A NCAC 27E .0101 and 10A NCAC 27G .1701. Review and Compliance: This SOP shall be reviewed annually to ensure compliance with regulatory requirements and alignment with best practices." Review on 4/30/25 of the 5th POP submitted (no signature) by the D/L/QP #2 dated 4/15/25 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Describe your plans to make sure the above happens. Direct care staff must attend to the safety needs of consumers in the facility prior to assessing the situation. Direct care Staff must contact either AP and or QP unless it is an emergency where the client needs medical attention first. At the point of contacting the proper authorities Staff must have a consumer file. Upon speaking about the consumer, staff can make reference to the client record. A copy of the consumer's face sheet should will be the second page in the clients file and will have emergency contact information as well as current medications being used by the	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 293	Continued From page 97	V 293		

consumer. When reporting a Level 2 and Level 3 incidents. Incident reports will need to be put into IRIS (INCIDENT RESPONSE IMPROVEMENT SYSTEM)(www.iris.ncdhhs.gov) within a 72 hour window. IRIS can be filled out by direct care staff with the assistance of AP,QP and or Director. A hard copy of the report can be printed out from the Iris website www.iris.dhhs.state.nc.us transferred to iris system when time is permitted. www.ncdhhs.gov/document/incident-response-improvement-system-iris-forms. Customer Service and Community Rights Team via fax [phone number] within specified timeframes and procedures. If a Iris report can not be filed electronically Direct care staff along with AP/QP will contact tailored plan QA/QI (Quality Assurance/Quality Improvement) and follow the instructions given. Consumers can be out of doors daily and have access to facilities and equipment for exercise several times a week."

Review on 4/30/25 of an addendum to the 5th Plan of Protection submitted (no signature) by the Director/Licensee/QP #2 dated 4/15/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Direct care staff along with qualified professional will monitor and redirect clients until a qualified plan is put in place where the consumers can give feedback and it is understood by the team that the plan is discussed and accepted by all parties."

Review on 4/30/25 of the 6th POP completed by the D/L/QP #2 dated 4/15/25 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? The qualified professional or the staff of their choosing may assist clients monitoring client as they open packages and mail. The packages will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 98 be logged in and the contaminants of the package will be written and signed by the consumer. The only phone restrictions and times and visitation will be discussed in meetings where the majority of the individuals who constructed the plan are in the meeting. Thats when phone restrictions can be lifted or placed on the consumer Describe your plans to make sure the above happens. When consumer packages and mail are delivered to the facility it can come into the facility. A supervisory staff person (AP, and/or QP) can be present or they can designate a direct care staff person to assist the client in opening the mail or packages. If there is a cost associated with the packages the consumer or legal guardian must cover the fee. Also all phone calls are to be supervised by a responsible staff person. Direct care or Direct care supervisor can supervise phone calls for the safety of other consumers and staff that are associated with the home. Supervisors need a minimal of 24-hour notice when consumers' friends and family want to visit consumers. Staff has the right to refuse anyone who may bring harm or outside instruments such as (contraband drugs, weapons etc.) to the program. It must be within reason and it must be discussed with QP and or AP. Consumers must have a do not call list and it must be discussed prior if any restrictions are placed on consumers prior to making any phone calls. Any restrictions must be discussed and understood in the initial assessment or during client family treatment (CFT) meetings. Consumers have the right to participate in religious worship as long enough advance time is given (42-72 hours) and received by the AP/QP. Consumers can be out of doors daily and have access to facilities and equipment for exercise several times a week."	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 99 This facility served clients aged 9 through 17 with diagnoses which included the following: Oppositional Defiant Disorder (ODD); Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; Depression; Encopresis and Enuresis. The facility did not train staff in client needs prior to staff working with clients. Clients were not assessed prior to admission as the facility was using their PCP completed by other providers several months before their admission. Client #1 had a history of elopement and suicidal ideation, and his treatment plan was not updated to address that behavior. Client #1 did not receive substance use therapy or attend 12 step meetings as identified in his treatment plan. FC #3's treatment plan was developed without meeting with his treatment team. There was a total of 300 shifts and 72 days of progress notes not provided to show documentation of progress toward outcomes or services provided for the remaining review period of 2/14/25 - 4/10/25 for Client #1, Client #2, FC #3 and FC #4. The clients did not have face sheets in their client information binder at the facility to identify client's name, record number, date of birth, race, gender, marital status, and admission date. The information in the record reviews for the clients were verbally told by the D/L/QP #2 and found in their PCPs. The facility failed to provide coordination of care as clients missed therapy appointments, did not have therapy scheduled and the legal guardians were unaware of missed therapy appointments or changes in therapists. The FQP and QP #1 were not performing clinical and administrative responsibilities in the home for a minimum or 10 hours a week when the clients are awake. There was no oversight over emergency response as the HM was the emergency response for the	V 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 100	V 293		

facility while not working in the facility. The facility hired an AP on 3/24/26 and as of 4/9/25 was not working fulltime or working shifts in the facility. During 2/14/25 through 4/10/25 the facility was mostly staffed with one direct care staff while serving up to three clients. Multiple incidents of aggression and suicidal ideation occurred while only one direct care staff was working. Multiple staff reported that the D/L/QP #2 had the final say in staffing and would refuse staff requests for 2 staff on shift. The facility did not employ an LP since facility began re-admitting clients on 2/14/25. An LP did not provide clinical supervision as the FQP and QP #1 were supervised by the D/L/QP #2, with the D/L/QP #2 receiving no supervision. The clients had phone calls restricted to an assigned call day, one day a week, where the client must be on speaker phone and the phone call monitored by staff. There was no documentation of the phone call restriction in the clients treatment plan, that the legal guardian consented to the phone call restriction and approval from a Human Rights Committee for the phone call restriction. The facility did not complete and maintain incident reports as there were no internal incident reports for the facility provided other than 5 IRIS reports from 2/14/25 - 4/20/25. There was 6 calls to LE from 2/14/25 - 4/8/25 and no documentation of the incidents for 2 of the calls. There were no incident reports or documentation that a physician or pharmacist was contacted regarding Client #1 and Client #2's multiple medication administration errors. There were 3 separate level II incidents not reported within 72 hours of the facility becoming aware of the incidents and 2 separate level II incidents not reported to the LME/MCO. As a consequence to client behaviors leading up to an incident on 3/18/25 the FQP, the FAP and the D/L/QP #2 made the decision to put the clients on "lock

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 293	Continued From page 101 down" effective 3/19/25 where clients had to remain their bedroom during any free time outside of school and could only come out of their bedroom when asked to use the bathroom, was administered medications or mealtimes until 3/24/25. There was no documentation the "lock down" was used as a restrictive measure in the clients treatment plan, that the client's legal guardian consented to the "lock down" to be used as a restrictive measure and approval from a Human Rights Committee for "lock down." Staff began working in the facility without successfully completing alternatives to restrictive intervention training. North Carolina Interventions Plus (NCI+) certificates were provided by the D/L/QP #2 dated 1/9/25 for 3 staff who stated they did not take the training, were not on the NCI+ attendee roster dated 1/9/25 and the trainer stated he did not give the D/L/QP #2 the 3 certificates for staff dated 1/9/25. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 293		
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical	V 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 294	Continued From page 102 and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Qualified Professionals	V 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 294	Continued From page 103 performed clinical and administrative responsibilities a minimum of 10 hours each week with 70% of the time when clients were awake and present in the facility and failed to ensure the supervision of the Associate Professional (AP), oversight of emergencies, provision of direct psychoeducational services, participation and coordination of treatment plans, and provision of case management functions. The findings are: Review on 4/8/25 of the Qualified Professional (QP) #1's record revealed: -Hire date: 11/1/21. Attempted record review on 4/21/25 of the FQP's record revealed no record. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FQP hire date: 1/10/25. -The FQP date of separation: 3/23/25. Review on 4/9/25 of the D/L/QP #2 record revealed: -Hire date: 6/1/11. Review on 4/7/25 - 4/30/25 of facility records revealed: -No documentation that the QP #1, D/L/QP #2, and the FQP provided supervision to the Associate Professional (AP) or Former Associate Professional (FAP). -No documentation that the QP #1, D/L/QP #2, and the FQP provided psychoeducational services, coordination of treatment plans, and provision of case management functions for facility clients.	V 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 294	Continued From page 104 Interviews on 4/9/25 and 4/24/25 with Client #1 revealed: -"Didn't see [FQP] much, maybe every other week, maybe longer." -Had only seen the QP #1 in the facility once from 3/26/25-4/9/25. -The D/L/QP #2 did not discuss the incident with him after the police contact and hospital evaluation on 3/22/25, "...(D/L/QP #2) wasn't trying to hear what I had to say." Interview on 4/9/25 with Client #2 revealed: -Had only saw the QP #1 in the facility once from 3/26/25-4/9/25. Interview on 4/15/25 with Former Staff (FS) #2 revealed: -The FQP would come to the facility "to do the client charts (records), client info (information) books." -"Really don't know what she (FQP) did." -"I only physically saw her (FQP) 2 times (in the facility)." Interview on 4/7/25 with the House Manager (HM) revealed: -Was a Paraprofessional. -There was no response plan for oversight of emergencies which identified assistance from the QP #1, D/L/QP #2, or FQP. -"I am literally the on call (emergency response)...if there is an emergency when I am off shift. I am the one staff call." -"If I am on shift (during an emergency) I would call [Director/Licensee/QP #2 (D/L/QP #2)]." Interview on 4/15/25 with the FQP revealed: -Was responsible for supervision of direct care staff and the Associate Professional (AP). -Was supervised by the D/L/QP #2.	V 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 294	Continued From page 105 -Visited the facility "maybe once every other week...wouldn't go in (visit facility) often." -Did not coordinate and participate in treatment planning as the clients were "working off of the goals given to them from prior placement." -She did not "get any training or guidance for QP responsibilities." -She requested training from the D/L/QP #2 on the needs of the clients, responsibilities of the QP position, and did not receive it. "Didn't get it (trainings) the whole time (while QP of facility)." Interviews on 4/15/25 and 4/17/25 with the QP #1 revealed: -Started working as the primary QP on 3/26/25 after the FQP left employment. -Was supervised by the D/L/QP #2. -Supervised the AP. -Visited the facility 2 times a week. -"Staff in the home (facility) before me was messed up...no idea why...want to help him (D/L/QP #2) find another QP that can do the QP requirements, not looking to do this full term (at the facility)." Interviews on 4/7/25, 4/9/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -Supervised the QP#1 and FQP. -"I thought everything was getting handled." -Did not provide oversight over the FQP, "...was not checking behind the QP (FQP) assuming they (FQP) were doing their job." -Was not involved in the PCPs dated 3/26/25 for Client #1, Client #2 and FC #3. "I didn't handle that (PCPs)...[QP #1] created the new PCPs (3/26/25)." -The clients' PCP goals were not current, and the service notes were not done correctly because he "just assumed things were being done." -Created the AP work schedule, "...not really full	V 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 294	Continued From page 106 on full time (AP) on shift (not working on shift in the facility as of 3/26/25)." -"Date wanted it (lockdown) to be lifted was 3/24 (3/34/35) Monday of that week, I decided to lift the lockdown that Sunday (3/23/25)." -Did not feel like the clients on "ockdown from 3/19/25-3/23/25 was effective in correcting behaviors. -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 (V293) Scope for a Type A1 violation and must be corrected within 23 days.	V 294		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day	V 295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 295	Continued From page 107 day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to employ a full-time Associate Professional (AP) who ensured management of the daily operations of the facility, supervision of paraprofessionals, and participation in service planning meetings. The findings are: Attempted record review on 4/21/25 of the Former Associate Professional (FAP)'s record revealed no record. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FAP hire date: 1/20/25. -The FAP date of separation: 3/22/25. Requests for the FAP's job description were made to the D/L/QP #2 on 4/28/25 and 4/29/25. The job description was not provided by the time of the survey exit date. Interview on 4/14/25 with the FAP revealed: -Supervised by the D/L/QP #2 . -Had "never been in a treatment team meeting, wasn't informed of them." -When she asked the D/L/QP #2 about PCPs "he	V 295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 295	Continued From page 108	V 295		

didn't know how to do them."
-Had no documentation of Child Family Team (CFT) meeting notes she attended in February 2025 and March 2025 for Client #1.
-Had not attended CFT meetings for Client #2, FC #3 and FC #4.
-"Couldn't tell you what I was supposed to be doing because [D/L/QP #2] didn't tell me."

Review on 4/8/25 of the AP's record revealed:
-Hire date: 3/24/25.

Interview on 4/15/25 with the AP revealed:
-Hired 3/26/25.
-Supervised by the QP #1.
-Did not work full-time at the facility.
-Had only been to the facility 3 times from 3/26/25-4/15/25.
-"Monday, Thursday and Saturday will be the days I come in (to the facility)."
-She was "not directly supervising staff as of yet."
-Was unable to provide documentation of the CFT meetings she participated in on 4/10/25 for Client #1 and Client #2.

Requests for Client #1, Client #2, Former Client (FC) #4 and FC #4's CFT meeting notes were made to the D/L/QP #2 on 4/11/25. The CFT meeting notes were not provided by the time of the survey exit date.

Interview on 4/9/25 with Client #1 revealed:
-"Don't know her (AP)...been to the house (facility) once or twice...didn't really talk to me."

Interview on 4/9/25 with Client #2 revealed:
-Met the AP but she had not worked any shifts in the facility.

Interview on 4/14/25 with Staff #1 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 295	Continued From page 109 -The AP did not directly supervise her, "right now I report to [House Manager]..." -"Not sure who officially supervises me." Interview on 4/9/25 with the D/L/QP #2 revealed: -The AP started working with the facility on 3/26/25. -He created the AP's schedule and "lately it's been touch and go." -The AP was "...not really full time..." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 (V293) Scope for a Type A1 violation and must be corrected within 23 days.	V 295		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 296	Continued From page 110 for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, record review, and	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 296	Continued From page 111	V 296		

interview, the facility failed to ensure the minimum staffing ratio of two staff for up to four adolescents. The findings are:

Observations on 4/7/25 at approximately 3:45pm-4:30pm revealed:
-The House Manager (HM) worked alone with Client #1 and Client #2 for approximately 45 minutes before the Director/Licensee/Qualified Professional #2 (D/L/QP #2) arrived at the facility.

Observation on 4/8/25 at approximately 3:00pm-4:00pm revealed:
-The HM left the facility alone to go pick up Client #2. The D/L/QP #2 worked alone at the facility with Client #1 for approximately one hour. The HM returned to the facility with Client #2 after the HM transported Client #2 with no other staff.

Observation on 4/9/25 at approximately 3:00pm-4:00pm revealed:
-The HM left the facility alone to go pick up Client #2. The D/L/QP #2 worked alone at the facility with Client #1 for approximately one hour. The HM returned to the facility with Client #2 after the HM transported Client #2 with no other staff.

Review on 4/8/25 of Client #1's record revealed:
-Date of Admission: 2/14/25.
-Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression.
-Age: 17 years.
-History of suicidal ideation, property destruction, elopement, and physical aggression toward children which resulted in contact to law enforcement for assistance in crisis management.
-Treatment plan dated 3/26/25 revealed: "[Client #1] cannot be around other peers in his current

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 296	Continued From page 112 level 3 home (facility) due to behaviors." Review on 4/8/25 of Client #2's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); and Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -History of placement disruptions, impulsiveness, and hyperactivity. Review on 4/8/25 of Former Client #3 (FC #3)'s record revealed: -Date of Admission: 2/14/25. -Date of Discharge: 3/20/25. -Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis and Enuresis. -Age: 9 years. -History of emotional dysregulation which led to suicidal ideation. Review on 4/10/25 of Former Client #4 (FC #4)'s record revealed: -Date of Admission: 2/14/25. -Date of Discharge: 2/16/25. -Diagnoses: Post Traumatic Stress Disorder, chronic; ODD; and ADHD. -Age: 10 years. -History of difficulty dealing with abandonment issues, anxiety, hyperactivity, difficulty at school, impulsivity, lying, social immaturity, stealing, soiling himself, and is a victim of sexual and physical abuse and neglect. Review on 4/9/25 of Law Enforcement (LE) call history to the facility from 2/14/25 to 4/8/25 revealed: -At least three calls when one staff worked alone.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 296	Continued From page 113 -3/19/25 due to an assault on FC #3 by Client #1 that occurred on 3/18/25. -3/22/25 - 2 calls - due to Client #1's suicidal ideation. Interview on 4/9/25 with Client #1 revealed: - "Normally 1 staff work during the day, normally 1 staff at night, always been that way (one staff on shift)." -"There was one staff working that night (3/18/25), [Staff #1]" when he assaulted FC #3. LE were called the following day. -On 3/22/25, LE, Emergency Management Services (EMS) and a fire truck were called to the facility because Former Staff #2 (FS #2) "tried to say I was going to kill myself." FS #2 was working alone. - "[FS #2] told the cops (LE) I was trying to kill myself and I showed the cops...I hung my towel on my door. She (FS #2) said I punched [Client #2]...cops (lae enforcement) asked [Client #2] if I did and cops left. [FS #2] stayed outside (of the facility for an undisclosed time period)." -"[FS #2] said I was trying to hang myself." -FS #2 called LE a second time from outside, leaving Client #1 and Client #2 without staff supervision inside for at least fifteen minutes. FS #2 "didn't feel safe." -LE and the ambulance returned to the facility, and "they said I had to go with them." -Went to the hospital but was not admitted. Returned later to the facility with D/L/QP #2. FS #2 worked alone with Client #2 when Client #1 left for the hospital. D/L/QP #2 was alone when he transported Client #1 back to the facility after evaluation at the hospital. Interview on 4/9/25 with Client #2 revealed: -"Always been one staff..." -One staff generally one staff worked at night.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 296	Continued From page 114 -"One time (3/22/25) police (LE), ambulance and firetruck came (to the facility). Staff made up that [Client #1] was going to hang himself. [FS #2], police (LE) came to my room and asked me what happened...had no reason to take him, [FS #2] said she 'didn't feel safe'...no one else working that day." Interview on 4/16/25 with FC #3 revealed: -Had been at the facility when only one staff worked. -Felt safe until 3/18/25, "when the biggest kid (Client #1) pushed me." -When the assault occurred, Staff #1 watched television and didn't do anything to resolve the assault. Staff #1 worked alone that night (3/18/25). -Was evaluated at the hospital the following day (3/19/25) and was "okay." -The Former Qualified Professional (FQP) and the Former Associate Professional (FAP) made the decision to ensure FC #3 was evaluated at a hospital when they found out about the assault on 3/19/25. Interview on 4/16/25 with FC #3's Department of Social Services Legal Guardian (DSS LG) revealed: -Picked up FC #3 from the facility on 3/20/25. -Didn't feel that FC #3 was safe at the facility. Interview on 4/7/25 and 4/9/25 with the HM revealed: -Always transported clients by herself. - "At night it's usually one staff, really depends." -Weekday shifts were 1:30pm-5:00pm (1st), 5:00pm-10:00pm (2nd), and 10:30pm-7:00am (3rd). -Weekend shifts were 7:00am-7:00pm and 7:00pm to 7:00am.	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 296	Continued From page 115	V 296		

-FS #2 called LE on 3/22/25, Client #1 said he was going to hang himself. Client #1's behaviors, "make us (staff) feel unsafe." FS #2 worked alone when the incident occurred.

Interview on 4/14/25 with Staff #1 revealed:
-Worked second shift.
-Worked multiple times alone on shift, last time was about 2 weeks ago.
-Worked more than 5 times by herself.
-Transported clients by herself.
-Had not had any issues working by herself with the clients until the incident on 3/18/25 in which Client #1 and FC #3 got into a physical fight. During the fight, she worked alone.

Interviews on 4/14/25 and 4/15/25 with FS #2 revealed:
-Worked at least 10 shifts by herself.
-Scared to be on shift alone. Client #1, "is very irate...gets loud...cusses, popping hands, walking towards you."
-Knew that the FAP asked the D/L/QP #2 for 2 staff per shift on multiple occasions, but it was not approved.
-Staff #1 worked alone on 3/18/25 when Client #1 assaulted FC #3.
-Worked alone on 3/22/25 and contacted LE twice. "I was terrified."
-Had seen an increase in behavior from Client #1 since the 3/18/25 incident.
-Contacted the FQP the morning of 3/22/25 prior to calls to LE to request a second staff because Client #1 was upset and demonstrated increased agitation and aggression. A second staff was not sent to the facility to assist.
-On 3/22/25, "...heard the window open up... [Client #1] said he's going to hang himself and kill himself. When he said that, I called the police." Client #1 reported to LE that he was "just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 296	Continued From page 116	V 296		

playing."
-Had a hard time getting in touch with the D/L/QP#2 and the ambulance took Client #1 to the hospital.
-"I was the only staff there (at the facility) and it felt dangerous."
-The D/L/QP#2 went to the hospital and brought Client #1 back to the facility.
-"I left (employment) because [D/L/QP #2] doesn't take stuff serious until it happens."

Interview on 4/15/25 with FS #3 revealed:
-Transported clients alone.

Interview on 4/15/25 with FS #4 revealed:
-Worked alone for approximately 20 shifts and transported clients alone.

Interview on 4/14/25 with the FAP revealed:
-Started employment with the facility at the end of January 2025 and ended employment on 3/20/25 because "felt like I had to leave the home (facility) because he (D/L/QP #2) is not for (an advocate and care provider) the kids (clients)."
-Worked by herself on shift 2-3 times.
-Staff #1 worked alone during the incident on 3/18/25.
-Called LE on 3/19/25 to make a report that Client #1 assaulted FC #3 on 3/18/25 when she discovered the D/L/QP #2 did not report the incident.
-FC #3 was evaluated at the hospital on 3/19/25 after complaining about his back.
-Tried to get two staff approved to work each shift, but the D/L/QP #2 would not approve the requests.
-"Typically, it was just one staff (who worked during a shift). When I tried to get two staff on (schedule), I got push back from [D/L/QP #2] about paying two people instead of one."

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 296	Continued From page 117 -Staff would transport clients by themselves. -D/L/QP #2 only wanted one staff on shift. Interview on 4/15/25 with the FQP revealed: -Started in the middle of January 2025 at sister facility A and ended employment with the facility in the middle of March 2025. -One staff on shift was "pretty routine...as long as I was there, there was only one staff on shift." -Talked to the D/L/QP #2 about having 2 staff on shift multiple times. -It was ultimately the D/L/QP #2's decision about staffing ratios. -The clients missed scheduled therapy appointments due to staff not taking them. -"[Client #1] was supposed to go (to therapy) weekly, but staff wasn't getting him there weekly, [Client #2] missing appointments as well." -"Hard to take clients to appointments with one staff on shift, think staffing may have been the issue why appointments (therapy) were missed." Interview on 4/15/25 with the Assoiate Professional (AP) revealed: -Started 4/1/25 or 4/2/25. -Staff scheduling was part of her responsibilities. -Understood that 2 staff needed work for up to 4 clients in the facility. -Not aware one staff worked alone with clients in the past. Interview on 4/15/25 with the Qualified Professional (QP) #1 revealed: -Assumed responsibilities as the facility's QP on 3/26/25. -Aware of the required staff/client ratios. -"To my knowledge, it's been 2 staff on shift." -There have been no calls to LE for the clients. Interviews on 4/9/25, 4/24/25, and 4/29/25 with	V 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 296	Continued From page 118 the D/L/QP #2 revealed: -Regarding 1 staff observed on shift on 4/7/25, "I was around the corner, normally have 2 staff on shift." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 and must be corrected within 23 days.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy	V 297		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 297	Continued From page 119 services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to employ a Licensed Professional (LP) to ensure clinical supervision, therapy services, and participation in treatment plans or overall programmatic issues. The findings are: Attempted review of the LP's personnel record and interview on 4/8/25 with the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -No personnel record for an LP was available as there was no LP employed at the facility since the facility began re-admitting clients on 2/14/25. Review on 4/8/25 of Client #1's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression. -Age: 17 years. -History of suicidal ideation, property destruction, elopement, and physical aggression toward children which resulted in contact to law enforcement for assistance in crisis management. -Treatment plan dated 3/26/25 revealed: "[Client #1] cannot be around other peers in his current level 3 home (facility) due to behaviors." -No documentation of the facility providing LP services related to therapy or development of treatment plans.	V 297		

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 297	Continued From page 120 Review on 4/8/25 of Client #2's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); and Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -History of placement disruptions, impulsiveness, and hyperactivity. -Treatment plan dated 3/26/25 revealed: "[Client #2] exhibits destructive behaviors at the school and at the home. [Client #2] is rebellious and exhibits impulsive actions." -No documentation of the facility providing LP services related to therapy or development of treatment plans. Review on 4/8/25 of Former Client #3 (FC #3)'s record revealed: -Date of Admission: 2/14/25. -Date of Discharge: 3/20/25. -Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis; and Enuresis. -Age: 9 years. -History of emotional dysregulation which led to suicidal ideation. -Treatment plan dated 3/26/25 revealed: "[FC #3] struggles with managing his emotions which has led to him experiencing suicidal ideations." -No documentation of the facility providing LP services related to therapy or development of treatment plans. Review on 4/20/25 of Former Client #4 (FC #4)'s record revealed: -Date of Admission: 2/14/25. -Date of Discharge: 2/16/25. -Diagnoses: Post Traumatic Stress Disorder,	V 297		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 297	Continued From page 121 chronic; ODD; and ADHD. -History of difficulty dealing with abandonment issues, anxiety, hyperactivity, difficulty at school, impulsivity, lying, social immaturity, stealing, soiling himself, and is a victim of sexual and physical abuse and neglect. -Age: 10 years. -No documentation of the facility providing LP services related to therapy or treatment strategies. Review on 4/8/25 of the Qualified Professional (QP) #1's record revealed: -Hire date: 11/1/21. -No documentation of clinical supervision with an LP. Review on 4/23/25 of the Former Qualified Professional (FQP) 's record revealed: -Hire date: 1/10/25. -Date of separation: 3/23/25. -No documentation of clinical supervision with an LP. Review on 4/7/25 - 4/30/25 of facility records revealed: -No documentation of the facility providing LP involvement regarding overall programmatic issues. Interviews on 4/9/25 and 4/24/25 with Client #1 revealed: -Was "not on a schedule" to see a therapist (LP). -"...saw one (therapist) a couple weeks ago (prior to 4/9/25), don't know name." -LP's had not come to the facility. -Had "no group therapy" in the facility. -Did not receive substance use therapy or attend 12 step meetings as identified in his treatment plan.	V 297		

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 297	Continued From page 122 -Had not seen a therapist from 4/9/25-4/24/25, "don't know why not...been about a month since I saw a therapist (LP)." -"Helpful to have someone else (LP) to talk to other than the staff in the home (facility)." Interview on 4/23/25 with Client #1's Mother/Legal Guardian revealed: -Believed Client #1 had a new therapist but could not identify how often Client #1 met with the new therapist. -"Don't know what happened with last therapist (LP) (as of 4/23/25)." -Client #1 did not receive any therapy services from an LP at the facility. -"Nobody talked to me about continuing substance use therapy for Lakeview (facility)." Interviews on 4/9/25 and 4/24/25 with Client #2 revealed: -There was no LP at the facility; "...never (visit) to this house (facility)..." Interview on 4/16/25 with Former Client (FC) #3 revealed: -There was no LP at the facility. Interview on 4/9/25 with the Local Management Entity/Managed Care Organization representative revealed: -The D/L/QP #2 did not have an active LP on staff. Interview on 4/14/25 with the Former Associate Professional (FAP) revealed: -The facility did not employ an LP. -Prior to March 2025 "him (Client #2) and [Client #1] were missing appointments (therapy)...wasn't bi-weekly, no schedule."	V 297		

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V 297	Continued From page 123 Interview on 4/15/25 with the FQP revealed: -The facility did not employ an LP and "...no therapists came to the home (facility)..." -Had not received clinical supervision by an LP while working at the facility. Interview on 4/15/25 with the QP #1 revealed: -Had not received clinical supervision by an LP. Interview on 4/8/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -There was "no LP assigned (employed) for the facility...no assigned LP providing clinical oversight as of now." -"Therapist (LP) haven't been coming to the facility." -There was "previously no oversight over [FQP] (by an LP)." -The clinical oversight for the facility was "[QP #1] comes in and we have group once a week, gathers the info (information) for the PCPs (Person Centered Plans)." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"1700 (facility rule requirements) is new to me...1700 world is a different world..." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 297		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 364	Continued From page 124 § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a	V 364		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 364	Continued From page 125	V 364		

violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;
b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or
c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;
(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;
(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Keep and spend a reasonable sum of his own money;
(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and
(10) Have access to individual storage space for his private use.
(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 364	Continued From page 126 vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 364	Continued From page 127 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 364	Continued From page 128 renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all client rights in a 24 hour facility affecting 2 of 2 clients (#1 and #2). The findings are: Review on 4/8/25 of Client #1's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression. -Age: 17 years. -No documentation of phone call restriction in treatment plan. -No documentation that a legal guardian consented to phone call restriction. -No documentation of approval from a Human Rights Committee for phone call restriction. Review on 4/8/25 of Client #2's record revealed: -Date of Admission: 2/14/25.	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 364	Continued From page 129 -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -No documentation of phone call restriction in treatment plan. -No documentation that a legal guardian consented to phone call restriction. -No documentation of approval from a Human Rights Committee for phone call restriction. Interview on 4/24/25 with Client #1 revealed: -Could make "one" phone call on Mondays and calls had to be on speaker phone with staff present. -He did not like that his phone calls had to be on speaker phone. -Asked several times to make phone calls on days that were not his assigned call day and staff would tell him "no." -He asked to call his mother/legal guardian on 3/24/25 and "[Director/Licensee/QP #2 (D/L/QP #2)] said 'no' because I just got off lockdown." -The assigned day to make a phone call on Monday was "annoying...makes me more mad." Interview on 4/16/25 with Client #1's Mother/Legal Guardian revealed: -Client #1's assigned day to make phone calls was on Mondays and "always been that way." -"Only time facility lets him (Client #1) make calls is on Mondays." -Called the facility Sunday 4/6/25 to speak to Client #1 and staff told her "his (Client #1) call day is Monday" in which she "had to ask again to get to talk to [Client #1]." Interview on 4/24/25 with Client #2 revealed: -Could not remember which day his assigned day	V 364		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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V 364	Continued From page 130 was to make phone calls. Interview on 4/17/25 with Former Staff (FS) #2 revealed: -Client's (all) assigned day to make phone calls was "expectation in the home (facility)." -Client #1's assigned day to make calls was on Mondays. -She was told by the D/L/QP #2 that Client #1 "can have one phone call a week on Mondays." -She was not sure when Client #2's assigned call day was, "[Client #2] didn't have anyone to call...he didn't ask to make any calls." -"Clients couldn't have (make or receive) any calls on any other day (or than their assigned call day), extra calls (not on assigned call day) had to be cleared by [D/L QP #2]." Interview on 4/17/25 with FS #4 revealed: -Clients were only allowed to make a phone call "on their designated day, one day a week." -Was not sure when Client #2's assigned call day was, he "never asked to use the phone." -"[Client #1's] phone call day was Monday if he didn't get in trouble." -Clients could not make calls to legal guardians on days that were not assigned. -If clients asked to make a call not on their assigned day, staff would tell the client "they can't make a call until their day." -The assigned day once a week for clients to make a phone call was an "expectation in the home (facility)" and "was established already before I got there (worked in the facility)." Interview on 4/17/25 with Former Associate Professional (FAP) revealed: -She was "informed by [D/L/QP #2] that [Client #1] would get his calls on Mondays." -When Client #1 would ask to make a phone call	V 364		

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V 364	Continued From page 131	V 364		

not on his assigned day, "staff would ask [D/L/QP #2] and he wouldn't allow it."
-She did not know what Client #2's assigned day was to make phone calls.

Interview on 4/17/25 with the Associate Professional (AP) revealed:
-The clients had specific days to make calls.
-Client #1's assigned day to make phone calls was on Mondays.
-She "heard [D/L/QP #2] tell [Client #1] he can't call mom (Client #1's Mother/Legal Guardian) because it was not his day (assigned day to make phone calls)."
-She was "not sure" if Client #1's mother/legal guardian had the assigned call day set up for only Mondays.
-She was "not sure" what Client #2's assigned day was to make phone calls.

Interview on 4/17/25 with the Former Qualified Professional (FQP) revealed:
-The assigned day once a week for clients to make a phone call was already in place "prior to me starting (work at the facility)."
-Client #1's assigned day to make phone calls was on Mondays.
-Did not know Client #2's assigned day to make phone calls. "(Client #2) didn't make calls."
-The time limit for phone calls was 15-20 minutes and "depended on behaviors."
-"Clients can only make and receive calls on designated day."

Interview on 4/17/25 with the Qualified Professional (QP) #1 revealed:
-Was not aware that clients had limited phone calls and these calls could only occur on their assigned day.
-Clients "should be able to ask to make a call

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V 364	Continued From page 132 whenever they want to." Interview on 4/24/25 with the D/L/QP #2 revealed: -The clients had a "designated day to make phone calls." -All clients' phone calls were monitored by being on speaker phone. -"Client goes to a space that they feel comfortable, but it is a supervised call." -He "heard staff tell [Client #1] they can't make a call because it wasn't his call day" and he "rectified the situation" by talking with staff and Client #1 around mid-March 2025. -Was "not against" clients using the phone on days other than their assigned call day. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 364		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible	V 366		

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V 366	Continued From page 133	V 366		

for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident

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V 366	Continued From page 134 and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 135 This Rule is not met as evidenced by: 10A NCAC 27G .0603 Incident Response Requirements For Category A and B Providers (V366). Based on record review and interview, the facility failed to implement policies governing their reporting and response to level I and II incidents as required. The findings are: Review on 4/8/25 of the facility's incident reports for 2/14/25 - 4/8/25 revealed: -No documentation of the 2/16/25 incident involving Client #1 making threats to staff which required a report to Law enforcement (LE). -No documentation of the 3/22/25 incident involving Client #1 experiencing suicidal ideation which required a report to LE and hospital evaluation. -No documentation of incident reports regarding Client #1 and Client #2 medication administration errors. Review on 4/9/25 of LE call history to the facility from 2/14/25 to 4/8/25 revealed: -6 calls to law enforcement for assistance with clients' behaviors. -2/16/25, Client #1 made threats to staff. -2/16/25 (2 calls), Former Client (FC) #4 expressed suicidal ideation and self-harm. -3/19/25, Client #1 assault of FC #3 on 3/18/25. -3/22/25 (2 calls), Client #1 expressed suicidal ideation. Review on 4/8/25 of the North Carolina Incident Response Improvement System (NC IRIS)	V 366		

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V 366	Continued From page 136 revealed: -2/16/25: "[FC #4] indicated to staff after becoming extremely frustrated and he stressed to several staff that he wanted to 'Kill Himself.' After expressing this to staff he began banging his head on door molding. Staff stepped in the middle to stop the consumer from banging his head." LE was notified. -3/18/25: "[Client #1] was upset with the other consumer (FC #3) involved and picked him (FC #3) up out of his bed and threw him against the wall. Which resulted in bruising to the other consumer." LE was notified on 3/19/25. -3/18/25: "[FC #3] was picked up from his bed and thrown into the wall by another consumer (Client #1) in the group home." LE was notified. FC #3 was not taken for medical attention until 3/19/25. -4/16/25: "Client became upset staff implemented a no electronic policy. The client became upset and got verbal and threatened to get physical. Law enforcement was dispatched and he continued with the threats for several hours." 4/20/25: "Client (Client #1) put a hole in the sheetrock in his bedroom wall." Review on 4/7/25-4/30/25 of facility records revealed: -No documentation of attending to the health and safety needs of the individuals involved in the incident, determining the cause of the incident, developing and implementing corrective measures, developing and implementing corrective measures to prevent similar incidents, and assigning person(s) to be responsible for implementation of the corrections and preventative measures for the above mentioned incidents. Interviews on 4/9/25 and 4/24/25 with Client #1	V 366		

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V 366	Continued From page 137 revealed: -"Went without my meds (medications) for about a month, almost all of them...I felt horrible...agitated." -The Director/Licensee/Qualified Professional (D/L/QP #2) or Former Staff #2 did not discuss the incident with him after the police contact and hospital evaluation on 3/22/25. -When he was upset "no staff would try to talk to me...offer me anything to help calm me down." Interview on 4/9/25 with Client #2 revealed: -"I missed meds sometimes because they (facility) didn't have the refills, don't know which ones...the morning take 2 pills, at night take 3 pills, so I know if it is off ..." Interview on 4/16/25 with FC #3 revealed: -On 2/16/25 FC #4 had to go to the hospital because "he (FC #4) was acting mean." -On 3/18/25 "the biggest kid (Client #1) pushed me...got hurt a little bit." -"Staff didn't break up the fight (3/18/25)...staff saw [Client #1] run in my room and didn't do anything about it." -Went to the hospital on 3/19/25 and the doctor "said I was okay." Interviews on 4/8/25, 4/24/25, 4/28/25 and 4/29/25 with the D/L/QP #2 revealed: -Acknowledged the facility did not have any documentation of incident reports and response to incidents. -Did not know that medication errors needed to be documented. -Facility staff and himself debriefed with clients after incidents but "was not documented." -"Normally we just talk with the clients about it (incident), not a whole lot of dialog back and forth (between staff and client)."	V 366		

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V 366	Continued From page 138 -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and	V 367		

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V 367	Continued From page 139 (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:	V 367		

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V 367	Continued From page 140 (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level II incidents to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incidents. The findings are: Review on 4/9/25 of Law Enforcement (LE) call history to the facility from 2/14/25 to 4/8/25 revealed: -6 calls to law enforcement for assistance with clients' behaviors. -2/16/25, Client #1 made threats to staff. -2/16/25 (2 calls), FC #4 expressed suicidal ideation and self-harm. -3/19/25, Client #1 assault of FC #3 on 3/18/25. -3/22/25 (2 calls), Client #1 expressed suicidal	V 367		

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V 367	Continued From page 141 ideation. Review on 4/8/25 of the facility's incident reports for 2/14/25 - 4/8/25 revealed: -No documentation of the 2/16/25 incident involving Client #1 making threats to staff which required a report to LE. -No documentation of the 3/22/25 incident involving Client #1 experiencing suicidal ideation which required a report to LE and hospital evaluation. Review on 4/8/25 of the North Carolina Incident Response Improvement System (NC IRIS) report which involved FC #4 dated 2/17/25 completed by the Director/Licensee/ QP #2 (D/L/QP #2) revealed: -Date of incident: 2/16/25. -Date learned of incident: 2/16/25. -Submitted 2/17/25. -Level II incident. -Describe the Cause of the Incident: "[FC #4] indicated to staff after becoming extremely frustrated and he stressed to several staff that he wanted to 'Kill Himself.' After expressing this to staff he began banging his head on door molding. Staff stepped in the middle to stop the consumer from banging his head." LE was notified. -The IRIS report did not include information regarding the 2 calls to LE and hospitalization resulting from the incident. Review on 4/8/25 of the NC IRIS report which involved Client #1 dated 3/24/25 completed by the Former Qualified Professional (FQP) revealed: -Date of incident: 3/18/25. -Date learned of incident: 3/19/25. -Submitted 3/24/25. -Level II incident.	V 367		

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LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 367	Continued From page 142 -Describe the cause of this incident: "[Client #1] was upset with the other consumer (Former Client FC) #3) involved and picked him (FC #3) up out of his bed and threw him against the wall. Which resulted in bruising to the other consumer." LE was notified on 3/19/25. -LME/MCO was not notified of the incident within 72 hours. Review on 4/8/25 of the NC IRIS report which involved FC #3 dated 3/24/25 completed by the FQP revealed: -Date of incident: 3/18/25. -Date learned of incident: 3/19/25. -Submitted 3/24/25. -Level II incident. -Describe the cause of this incident: "[FC #3] was picked up from his bed and thrown into the wall by another consumer (Client #1) in the group home." LE was notified. -The IRIS report did not include information regarding FC #3's hospital visit on 3/19/25 resulting from the incident on 3/18/25. -LME/MCO was not notified of the incident within 72 hours. Review on 4/23/25 of the NC IRIS report which involved Client #1 dated 4/21/25 completed by the Director/Licensee/Qualified Professional #2 (D/L/QP #2) and the Qualified Professional (QP) #1 revealed: -Date of incident: 4/16/25. -Date learned of incident: 4/16/25. -Submitted 4/21/25. -Level II incident. -Describe the cause of this incident: "Client became upset staff implemented a no electronic policy. The client became upset and got verbal and threatened to get physical. Law enforcement was dispatched and he continued with the threats	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 367	Continued From page 143	V 367		

for several hours."
-LME/MCO was not notified of the incident within 72 hours.

Interview on 4/14/25 with Former Staff #2 revealed:
-Contacted the police twice on 3/22/25 as instructed by the FQP due to Client #1 stating he was going to "hang himself and kill himself."
-Client #1 went to the hospital on 3/22/25 then arrived back at the facility with the D/L/QP #2.

Interview on 4/14/25 with the Former Associate Professional (FAP) revealed:
-Contacted LE on 3/19/25 due to Client #1 assaulting FC #3 on 3/18/25.
-Received a call from facility staff on 3/19/25 that FC #3 complained about his back and she "told staff to take him to the ER (emergency room) to get evaluated."
-"There wasn't orientation or any training for me for incident reporting...informed [D/L/QP #2] about incident form on state website (IRIS)."
-"At first, [D/L/QP #2] said he was going to do (complete) the incident reports. I believe [FQP] took charge and did (completed) the reports (IRIS)."

Interview on 4/15/25 with the QP #1 revealed:
-Had completed one IRIS report for 4/16/25 incident which involved Client #1. The incident report was completed on 4/21/25.
-The Associate Profesional (AP) and himself were responsible for completing IRIS reports.
-"...staff have to understand protocol for reporting incidents."

Interview on 4/15/25 with the FQP revealed:
-Had completed one IRIS report for Client #1 and one IRIS report for FC #3 on 3/24/25 for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 367	Continued From page 144 3/18/25 incident. -Was not notified of the 3/18/25 incident until 3/19/25. -Was responsible for completing IRIS reports for the facility but "was not aware of the IRIS reporting requirements." -She "had no training on how or what to do with the IRIS report...doing everything to the best of my ability with no training." Interviews on 4/8/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -Had completed two IRIS reports on 4/21/25 for Client #1 and one IRIS report on 2/17/25 for FS #4. -"The key is learning which level the incident is, I am learning the differences between level 1, 2, 3 incidents now." -The AP, QP #1 and he would "complete IRIS reports within 24-48 hours (of learning of the incident)." -The facility will do "separate incident reports moving forward (internal incident reports for facility and IRIS reports)." -"(Former) Staff who left were responsible for the incident reports and everything they were supposed to be doing wasn't done." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 145	V 513		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review and interview, the facility did not promote a respectful environment using the least restrictive and most appropriate settings and methods affecting 2 of 2 current clients (#1 and #2) and 1 of 2 former clients (FC #3). The findings are: Review on 4/8/25 of Client #1's record revealed:	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 513	Continued From page 146 -Date of Admission: 2/14/25. -Diagnoses: Oppositional Defiant Disorder (ODD); Attention Deficit Hyperactivity Disorder (ADHD); Anxiety; and Depression. -Age: 17 years. -No documentation of "lockdown" to be used as a restrictive measure in treatment plan. -No documentation that a legal guardian consented to "lockdown" to be used as a restrictive measure. -No documentation of approval from a Human Rights Committee for "lockdown" to be used as a restrictive measure. Review on 4/8/25 of Client #2's record revealed: -Date of Admission: 2/14/25. -Diagnoses: Major Depressive Disorder (MDD), recurrent, mild; ADHD; Generalized Anxiety Disorder (GAD); Unspecified Trauma and Stress Related Disorder. -Age: 10 years. -No documentation of "lockdown" to be used as a restrictive measure in treatment plan. -No documentation that a legal guardian consented to "lockdown" to be used as a restrictive measure. -No documentation of approval from a Human Rights Committee for "lockdown" to be used as a restrictive measure. Review on 4/8/25 of FC #3's record revealed: -Date of Admission: 2/14/25. -Date of Discharge: 3/20/25. -Diagnoses: ADHD, predominantly inattentive type; ODD; MDD, single episode moderate; Encopresis and Enuresis. -Age: 9 years. -No documentation of "lockdown" to be used as a restrictive measure in treatment plan. -No documentation that a legal guardian	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 147	V 513		

consented to "lockdown" to be used as a restrictive measure.
-No documentation of approval from a Human Rights Committee for "lockdown" to be used as a restrictive measure.

Review on 4/8/25 of the North Carolina Incident Response Improvement System (NC IRIS) report for Client #1 dated 3/24/25 completed by the Former Qualified Professional (FQP) revealed:
-Date of incident: 3/18/25.
-Date learned of incident: 3/19/25.
-Submitted 3/24/25.
-Level 2 incident.
-"Describe the cause of this incident: [Client #1] was upset with the other consumer (FC #3) involved and picked him (FC #3) up out of his bed and threw him against the wall. Which resulted in bruising to the other consumer (FC #3)." Law enforcement was notified on 3/19/25.
Review on 4/8/25 of the NC IRIS report for FC #3 dated 3/24/25 completed by the FQP revealed:
-Date of incident: 3/18/25.
-Date learned of incident: 3/19/25.
-Submitted 3/24/25.
-Level 2 incident.
-"Describe the cause of this incident: [FC #3] was picked up from his bed and thrown into the wall by another consumer (Client #1) in the group home." Law enforcement was notified on 3/19/25.

Interviews on 4/9/25 and 4/24/25 with Client #1 revealed:
-The facility was "way more restrictive" than his prior placement which made him "...more mad..."
-Was on "lockdown" in the facility from the afternoon of 3/19/25 afternoon until the morning of 3/24/25.
-On 3/19/25 the Former Associate Professional (FAP) explained he was on "lockdown" due to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 148	V 513		

incident he was involved in the previous day.
While on "lockdown" he had to remain in his room during any free time outside of school and could only leave his room when he asked to use the bathroom, was administered medications, or at mealtime.
-When he arrived at the facility from school he had to remain in his room until the following morning when it was time to go to school again.
-While on "lockdown" he attempted to come out of his room and staff would tell him to go back to his room.
-When he asked staff if he could come out of his room while on "lockdown" staff would "tell me to stay in my room."
-Was "not allowed" to go outside of the facility while on "lockdown."
-To pass the time while on "lockdown" he did "nothing" in his room and "just slept."
-Staff "didn't offer" him any activity while he was in his room and on "lockdown."
-Staff told him he was off "lockdown" the morning of 3/24/25.
-His mother/legal guardian was not notified that he was on "lockdown" until he called her on 3/22/25 from the hospital due to evaluation for suicidal ideation on 3/22/25.

Interview on 4/16/25 with Client #1's Mother/Legal Guardian revealed:
-Was not aware Client #1 was on "lockdown" until he called her from the hospital on 3/22/25.
-Did not believe "lockdown" was effective in correcting Client #1's behaviors. "...Just makes [Client #1] act out even more..."
-"Six days of forced to be in your room is excessive for anybody."

Interviews on 4/9/25 and 4/24/25 with Client #2 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 149 -Was on "lockdown" in the facility from the afternoon of 3/19/25 until the morning of 3/24/25. -"Went on lockdown for a week. Could only come out of room to eat and use the bathroom." -On 3/19/25 the FAP explained that he was on "lockdown" and had to remain in his room upon arriving to the facility from school, could only "come out (of his room) to eat and use the bathroom." -Asked to come out of his room while on "lockdown" and "staff said 'no.'" -Staff "didn't give" him any activity while he was in his room and on "lockdown." -He "had a journal already" in his room and played "tic tac toe tournaments with myself" during the days he was on "lockdown." -Was not allowed to go outside of the facility while on "lockdown." -"...Asked to go outside and [Director/Licensee/QP #2 (D/L/QP #2)] said 'no.'" -Was "supposed to come off (lockdown) on Friday (3/21/25), something happened on Saturday (3/22/25) and then it (lockdown) went on until Monday morning (3/24/25)." Interview on 4/16/25 with Client #2's Department of Social Services Legal Guardian (DSS LG) revealed: -Was not aware Client #2 was on "lockdown" from 3/19/25-3/24/25. -Did not believe "lockdown" was effective in correcting Client #2's behaviors, "...one thing if you take away TV (television) time or toys but forced to be in your room is not okay." -Client #2 having to remain in his room during any free time outside of school and being allowed to only leave his room when he asked to use the bathroom, was administered medications, or at mealtime from 3/19/25-3/24/25 was "absolutely unacceptable."	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 150 Interview on 4/16/25 with Former Client (FC) #3 revealed: -On 3/19/25 the FAP explained that he was on "lockdown" and he had to "stay in room, can come out to use bathroom and take medicine." -Staff didn't offer him any activity while he was in his room on "lockdown" and "we had to use what we had in our rooms...had books." -He "came home from school (3/19/25) stayed in room, came out to do chores then went back to my room until I went to hospital (evening of 3/20/25)." Interview on 4/16/25 with FC #3's DSS LG revealed: -Was not aware FC #3 was on "lockdown" from 3/19/25-3/20/25. -"[FC #3] would interpret isolation in room as punishment." -Removed FC #3 from the facility because it "...was not a safe environment..." Interview on 4/9/25 with the House Manager revealed: -The FQP and the FAP instructed her the clients were on "lockdown" and "can't do anything, only come out of their rooms to eat, use the bathroom, couldn't play anything, just had to be in their rooms" starting on 3/19/25. -The clients "didn't like" being on "lockdown" and it "was a way to keep clients separated." -"We (staff) didn't know how long 'lockdown' was going to last." -"Lockdown" was "not in any treatment plan, first time I heard of it." -"Didn't even know we can do that (have clients stay in their rooms during free time outside of school)."	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 151 Interview on 4/14/25 with Staff #1 revealed: -She had a "lesson" on what "lockdown" was from the FQP and the FAP, "kids (clients) can leave their room for meals and bathroom then go back to room." -"I thought 'lockdown' meant can't go outside, didn't know it was they could only be in their room and no TV, nothing to do." -"Kids (clients) told me 'lockdown' was all the way up to the weekend." -"They (clients) already got a lot going on, makes things worse, don't think that's right." -"Feel like 'lockdown' makes them (clients) more upset." Interview on 4/15/25 with FS #2 revealed: -She worked on 3/19/25 and 3/22/25 while the clients were on "lockdown." -The D/L/QP #2 called her during the morning of 3/19/25 and told her the "clients are on lockdown, have to be in their rooms and can only come out to eat, get meds (medications) and use the bathroom and have to go back in their room for 4 or 5 days." -"[D/L/QP #2] said it was done for safety precautions, that clients need to be in their rooms for not following house rules and then 3/18/25 incident (Client #1 pushing FS #3)." -If the clients asked to leave their rooms while on lockdown, she would tell them "no" since the clients "knew they were on lockdown." -"[Client #2] asked how long we have to do this (stay in his room)...told him 5 days." -While on lockdown the clients were in their rooms coloring or writing. "[Client #1] would just sleep most of the time while in his room." -"Didn't feel comfortable doing 'lockdown' but that was the order he (D/L/QP #2) gave." -"Lockdown" was "a form of punishment...definitely thought it was restricting	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 152 the clients and thought we (facility) couldn't do it." Interview on 4/14/25 with the FAP revealed: -The D/L/QP #2 informed her the clients would be on "lockdown" and "were not going to be able to do anything, no TV, no outings" on a phone call the morning of 3/19/25, effective that day. -The clients were put on "lockdown" due to "cussing, name calling, and putting hands on each other leading up to incident on 3/18/25 (Client #1 assaulted FS #3)." -Had explained to the clients and staff on 3/19/25 that "lockdown" meant "they (clients) will not be able to watch TV, no outings and had to stay in their rooms...could only come out to eat or use the bathroom." -Clients being instructed to go to their rooms was "a part of a consequence" of behavior and the clients would "go to room for a time limit." -Did not know how long the clients were to be on "lockdown...[D/L/QP #2] didn't tell me for how long." -The clients "should have been given some worksheets" to entertain themselves while in their rooms but "don't know for sure if that happened." -Did not agree with putting the clients on "lockdown." -The facility had "no strategies, no plan, no organization, no structure for the kids (clients)." -She was "concerned about the kids (clients)" and felt like the facility was "just a housing (location)...not really trying to help the kids (clients)." Interview on 4/15/25 with the FQP revealed: -As a consequence to clients' behaviors leading up to the 3/18/25 incident, the D/L/QP #2, the FAP, and the FQP decided to put the clients on "lockdown" effective 3/19/25. The clients had to remain in their rooms during any free time outside	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

(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) COMPLETE DATE
V 513	Continued From page 153 of school and could only come out of their rooms when they asked to use the bathroom, was administered medications, or at mealtimes. -Had a phone call the morning of 3/19/25 with the D/L/QP #2 and the FAP about "lockdown as a punishment put in place." -Lockdown meant the clients "could not come out of room, could only eat, take meds (medications) or use bathroom." -The clients were put "on restriction ('lockdown')" as a "consequence to behavior leading up to 3/18/25 incident." -"[Client #1] would ask to come out of the room a lot because he was tired of being in the room, staff would tell him he would have to stay in the room." -There was a "big concern for [Client #1's] aggression...with us (facility) having one staff on shift and female staff we were concerned with something taking place." -"Lockdown" was "more a preventative measure...keep everyone (clients) separate." -"Lockdown helped staff feel safe because staff didn't feel safe." Interviews on 4/8/25, 4/10/25, 4/24/25, and 4/28/25 with the D/L/QP #2 revealed: -The "lockdown" was "never 6 days...it was 3 days." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HOUSE	106 LAKEVIEW DRIVE GROVER, NC 28073

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V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human	V 536		

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	MHL023-239	A. BUILDING: _____ B. WING _____	C 05/01/2025

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V 536	Continued From page 155 behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an	V 536		

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V 536	Continued From page 156	V 536		

instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may

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V 536	Continued From page 157 request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 current staff (Staff #1) and 5 of 5 former staff (Former Staff (FS) #2, FS #3, FS #4, Former Associate Professional (FAP), and Former Qualified Professional (FQP)) received initial training in alternatives to restrictive interventions. The findings are: Review on 4/23/25 of Staff #1's record revealed: -Hire date: 1/27/25. -National Crisis Interventions Plus (NCI +) certificate of completion dated 1/9/25. Review on 4/23/25 of FS #2's record revealed: -Hire date: 3/10/25. -Date of separation: 4/9/25. -No documentation of training in alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 158 Review on 4/23/25 of FS #3's record revealed: -Hire date: 3/31/25. -Date of separation: 4/6/25. -No documentation of training in alternatives to restrictive interventions. Review on 4/23/25 of FS #4's record revealed: -Hire date: 3/20/25. -Date of separation: 4/7/25. -No documentation of training in alternatives to restrictive interventions. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FAP hire date: 1/20/25. -The FAP date of separation: 3/22/25. Review on 4/23/25 of the FAP's record information provided by the Director/Licensee/QP #2 (D/L/QP #2) revealed: -NCI + certificate of completion dated 1/9/25. Interview on 4/21/25 the Director/Licensee/Qualified Professional #2 (D/L/QP #2) revealed: -The FQP hire date: 1/10/25. -The FQP date of separation: 3/23/25. Review on 4/23/25 of the FQP's record provided by the Director/Licensee/QP #2 (D/L/QP #2) revealed: -NCI + certificate of completion dated 1/9/25. Review on 4/23/25 of NCI + training roster provided by the NCI+ Trainer dated 1/9/25 revealed: -Staff #1, the FAP and the FQP were not listed as attendees.	V 536		

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V 536	Continued From page 159 Interview on 4/23/25 with the NCI+ Trainer who provided training for the facility on 1/9/25 revealed: -Last training he completed for the facility was on 1/9/25 and he "only trained one person, a male." -He had multiple cancellations for alternatives to restrictive interventions training with the Director/Licensee/QP #2 (D/L/QP #2). -"Training would be scheduled, and I would show up and no one would come." -If Staff #1, the FAP and the FQP participated in the 1/9/25 training, "they would have been on the 1/9/25 roster." -"The names on the certificates...those 3 (Staff #1, the FAP and the FQP) look a little different to me from the one I did on 1/9/25." -The difference on the NCI + certificates for Staff #1, the FAP and the FQP were "the color of the names, the red is a different shade and the lines under their names are different lengths." -"I'm so meticulous when I make these certificates, all them are uniform when I create them." -"I did not give [D/L/QP #2] certificates for the 3 additional individuals (Staff #1, the FAP and the FQP) for the 1/9/25 training." Interview on 4/14/25 with Staff #1 revealed: -She had "no official training on alternatives to restrictive interventions." Interview on 4/16/25 with the FAP revealed: -Did not take an NCI+ training while working for the D/L/QP #2. -Never met the NCI+ Trainer used by D/L/QP #2. -"Don't know why he (D/L/QP #2) would have a training certificate (NCI+) for 1/9/25." Interview on 4/16/25 with the FQP revealed: -Was not working for the facility on 1/9/25.	V 536		

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V 536	Continued From page 160 -She "did not" take an NCI+ training on 1/9/25 and there "should not be a certificate for NCI with my name on it." -"Never met [NCI+ Trainer]." Interview on 4/8/25, 4/24/25 and 4/28/25 with the D/L/QP #2 revealed: -Responsible for scheduling alternative to restrictive interventions training for staff. -The facility policy was that he "had 90 days to get staff trained in alternatives to restrictive intervention...thought it was okay." -"Know now moving forward staff have to have (training on) alternative to restrictive interventions before working with the kids (clients)." -Staff #1, the FAP and the FQP completed the NCI+ training on alternative to restrictive Interventions on 1/9/25. "I don't see how they didn't take it." -Was not sure why the FQP, the FAP and Staff #1 were not on the attendee roster dated 1/9/25 for NCI+ training on alternatives to restrictive interventions and why the staff said they did not participate in the training. -Received the training certificates from the 1/9/25 NCI+ training from the NCI+ Trainer. "I can't change a NCI+ training, I know coming into this that a lot of info (information) missing." -His role in the facility was to "put eyes on everything that is supposed to be done and if not put the right people in place to get things done." -"I was doing what I thought was necessary to run the business." -"I take full responsibility for the issues, it falls on me, need to have better systems in place." This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 violation and must be corrected within 23 days.	V 536		