

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/30/2025
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NAME OF PROVIDER OR SUPPLIER LAKESIDE AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 422 LAKESIDE AVENUE BURLINGTON, NC 27217
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(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
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on December 30, 2025. The complaints were unsubstantiated (intake #NC 00234381 and #NC00234385). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for six and has a current census of six. The survey sample consisted of audits of three current clients.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____