

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL096-092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/10/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 LAKEVIEW DRIVE GOLDSBORO, NC 27530</b>
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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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on April 10, 2026. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 3 current client.</p>	V 000		
V 112	<p><b>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</b></p> <p><b>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</b></p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that treatment plans were updated annually with written consent or agreement by the client or responsible party for 1 of 3 audited (#2). The findings are:</p> <p>Review on 4/10/26 of client #2's record revealed: -Admission Date: 7/9/10. -Diagnoses: Traumatic Brain Injury; Hypertension, Chronic Obstructive Pulmonary Disease, Diabetes and History of Spine Fracture -Treatment plan start date 12/5/24 and end date 12/4/25. -No documentation of a current treatment plan.</p> <p>Interview on 4/10/26 the Qualified Professional stated: -Client #2 had some medical issues that occurred in the fall of 2025 and it was unknown if client #2 would require complete use of a wheel chair. -An annual review had not yet occurred because he was waiting to see if client #2 would require a goal. -He realized that he should not have delayed the annual review and consent of client #2's treatment plan.</p>	V 112		