	-	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE	
		34G227	B. WING			04/	10/2024
NAME OF P	ROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FLOWE D	RIVE GROUP HOME				28 FLOWE DRIVE HARLOTTE, NC 28213		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	CFR(s): 483.475(d)(2 §416.54(d)(2), §418. §460.84(d)(2), §482. §483.475(d)(2), §484. §485.542(d)(2), §485. §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD I (2) Testing. The [facil to test the emergency must do all of the follo (i) Participate in a full community-based ever (A) When a commun accessible, conduct at exercise every 2 year (B) If the [facility] natural or man-made activation of the emel exempt from engagin community-based or functional exercise for actual event. (ii) Conduct an addition years, opposite the year this section is conduct (A) A second full-scal community-based or functional exercise; o (B) A mock disaster of (B) A mock disaster of	 a) a) a) a) a) b) a) b) b) b) b) b) c) <lic)< li=""> <lic)< li=""> <lic)< li=""> <lic)< li=""> <lic)< li=""> <lic)< li=""> <lic)< <="" td=""><td>E</td><td>039</td><td></td><td></td><td></td></lic)<></lic)<></lic)<></lic)<></lic)<></lic)<></lic)<>	E	039			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 04/14/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/14/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		34G227	B. WING _			04/	10/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FLOWE D	RIVE GROUP HOME				28 FLOWE DRIVE HARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	a facilitator and incluc a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (iii) Analyze the [facilit maintain documentati exercises, and emerg [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The I exercises to test the e annually. The hospic (i) Participate in a full community based eve (A) When a communit accessible, conduct a functional exercise ev (B) If the hospice exp man-made emergenc the emergency plan, t engaging in its next re community-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under parag is conducted, that ma to the following: (A) A second full-sca community-based or a exercise; or (B) A mock disaster o (C) A tabletop exercise	des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. ty's] response to and ton of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] tess that provide care in the hospice must conduct emergency plan at least e must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not in individual facility based very 2 years; or eriences a natural or by that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited le exercise that is a facility based functional	E	039			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G227 B. WING 04/10/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE FLOWE DRIVE GROUP HOME CHARLOTTE, NC 28213 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 2 E 039 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 921849

If continuation sheet Page 3 of 18

PRINTED: 04/14/2024

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G227 B. WING 04/10/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE FLOWE DRIVE GROUP HOME CHARLOTTE, NC 28213 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 3 E 039 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the followina: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the followina: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 921849

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PRINTED: 04/14/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2024 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		34G227	B. WING			04/	10/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FLOWE DF	RIVE GROUP HOME				328 FLOWE DRIVE		
				C	CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	exercises to test the e annually. The PACE of following: (i) Participate in an ar- is community-based; ((A) When a community accessible, conduct a facility-based function (B) If the PACE exper- man-made emergency the emergency plan, the engaging in its next re- based or individual, fa- exercise following the event. (ii) Conduct an ar- years opposite the ye exercise under parage is conducted that may the following: (A) A second full-scal community-based or i functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includ using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the PACI maintain documentati	E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not n annual individual, hal exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional onset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based r drill; or se or workshop that is led by les a group discussion, cally-relevant emergency f problem statements, r prepared questions e an emergency plan. E's response to and on of all drills, tabletop ency events and revise the	E	039			
	*[For LTC Facilities at (2) The [LTC facility] r	§483.73(d):] nust conduct exercises to					

Facility ID: 921849

If continuation sheet Page 5 of 18

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	D: 04/14/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		34G227	B. WING			04/	10/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RIVE GROUP HOME			e	628 FLOWE DRIVE		
				0	CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	test the emergency pl including unannounce emergency procedure ICF/IID] must do the f (i) Participate in an ar- is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-base following the onset of (ii) Conduct an addition may include, but is no (A) A second full-scale community-based or a functional exercise; on (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rele and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's of *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t	an at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise. [facility experiences an -made emergency that the emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to entation of all drills, tabletop pency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises y plan at least twice per year.	E	039			

Facility ID: 921849

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		34G227	B. WING			04/	10/2024
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
FLOWE D	RIVE GROUP HOME			-	628 FLOWE DRIVE CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	is community-based; (A) When a communitial accessible, conduct a facility-based function (B) If the ICF/IID experimentation (C) If the emergency plan, the emergency plan, the engaging in its next recommunity-based or if functional exercise for emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; of (B) A mock disaster d (C) A tabletop exercise a facilitator and include using a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emerg ICF/IID's emergency pleast annually. The H to test the emergency pleast annually. The H (i) Participate in a full-community-based; or (A) When a commaccessible, conduct a set of accessible, conduct a set of a functional exercise is a facilitator and include the information accessible, conduct a set of the emergency pleast annually. The H (i) Participate in a full-community-based; or (A) When a commaccessible, conduct a set of accessible, conduct a set of a construction accessible, construction ac	or ty-based exercise is not in annual individual, nal exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based llowing the onset of the onal annual exercise that of limited to the following: e exercise that is an individual, facility-based r lrill; or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop jency events, and revise the plan, as needed. 02] HA must conduct exercises r plan at HA must do the following: -scale exercise that is munity-based exercise is not	E	039			

Facility ID: 921849

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/14/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		34G227	B. WING			04/	10/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RIVE GROUP HOME			6	28 FLOWE DRIVE		
				c	CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (B) If the HHA exor man-made emerge of the emergency plar engaging in its next recommunity-based or i functional exercise fol emergency event. (ii) Conduct an addition opposite the year the exercise under paragrisis conducted, that limited to the following: (A) A second full-community-based or a functional exercise; or (B) A mock disassi (C) A tabletop exercise (B) A mock disassi (C) A tabletop exercise and emergency scenario, statements, directed requestions designed to plan. (iii) Analyze the HHA's documentation of all commergency events, are emergency plan, as networkshop at least annuled by a facilitator and discussion, using a natemergency plan, as networkshop at least annuled by a facilitator and discussion, using a natemergency scenario, and the emergency plan, as networkshop at least annuled by a facilitator and discussion, using a natemergency scenario, and the emergency scenario, and the emergency plan, as networkshop at least annuled by a facilitator and discussion, using a natemergency scenario, 	experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: -scale exercise that is an individual, facility-based r ter drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's eeded.	E	039			

Facility ID: 921849

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/14/2024 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	-	(X3) DATE SURVE COMPLETED	
		34G227	B. WING		_	04/1	0/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FLOWE D	RIVE GROUP HOME			628 FLOWE DRIVE CHARLOTTE, NC 2821	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions designed to plan. If the OPO exper man-made emergency the emergency plan, the engaging in its next ref following the onset of (ii) Analyze the OPO's documentation of all the emergency events, are OPO's] emergency plan. *[RNCHIs at §403.74 (d)(2) Testing. The RM exercises to test the exercises to test the temergency plan. (ii) Analyze the RNHC maintain documentati and emergency event emergency plan, as in This STANDARD is in Based on record revit facility failed to conduce emergency prepared The finding is: Review of the facility facility facility facility facility the exercises test the EPP. Interview with the quartices the temergency events the exercises the exercises the temergency events the exercises to the temergency events the exercises the temergency events the temergency events the exercises the temergency events the temergency	 b challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. as response to and maintain abletop exercises, and nd revise the [RNHCI's and an, as needed. 48]: NHCI must conduct emergency plan. The RNHCI cased, tabletop exercise at etop exercise is a group icilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, ts, and revise the RNHCI's needed. NHCI met as evidenced by: ew and interviews, the for exercises to test the ness plan (EPP) annually. 	E 03				

Facility ID: 921849

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		<u>0. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
		34G227	B. WING		04	/10/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FLOWE D	RIVE GROUP HOME			628 FLOWE DRIVE CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 039	Continued From page has not been a full-so facility-based exercise test the EPP.		E 039			
W 249	PROGRAM IMPLEM CFR(s): 483.440(d)(1		W 249			
each client must recein treatment program co interventions and serv and frequency to supp		ndividual program plan, ive a continuous active				
	Based on observatio reviews, the facility fa active treatment prog interventions were im the individual habilita clients (#1, #3, and # A. The facility failed to	not met as evidenced by: ns, interviews, and record illed to ensure a continuous ram consisting of needed uplemented as identified in tion plan (IHP) for 3 of 5 4). The findings are: o implement client #1's to using sign language. For				
	PM revealed client #1 activity and staff to as more blocks. Continu revealed client #1 to request more salad a the client's plate. Furt	roup home on 4/9/24 at 4:15 I to participate in a block sk the client if she would like ed observations at 5:25 PM point and make sounds to nd staff put more salad on ther observations at 5:27 PM inted at a serving bowl with ads. Subsequent				

Facility ID: 921849

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/14/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		34G227	B. WING			04	10/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FLOWE D	RIVE GROUP HOME				628 FLOWE DRIVE CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	observations revealed finish her salad alread during observations w client #1 to use sign la request for "more". Review of records for revealed an IHP dated of the IHP revealed a to request "more" usin request to staff with n prompts. Interview on 4/10/24 w disabilities profession client #1's IHP was cu with the QIDP confirm implement the client's B. The facility failed to program goal relative example: Observations in the g PM revealed client #3 meal. Continued obser revealed client #3 to f exit the dining area. F revealed client #3 to f kitchen sink. Subsequ that at no time was st client #3 with a Big M Observations in the g 8:15 AM revealed the client #3 if she had he observations revealed	d staff prompted the client to dy on her plate. At no time vas staff observed to prompt anguage to make her r client #1 on 4/10/24 d 3/19/24. Continued review program goal for client #1 ng sign language for her to more than three verbal with the qualified intellectual tal (QIDP) confirmed that urrent. Continued interview hed that staff should as current goals. to implement client #3's to using a Big Mac. For roup home on 4/9/24 at 5:06 8 to participate in the dinner ervations at 5:23 PM finish the dinner meal and Further observations take her dirty dishes to the uent observations revealed taff observed to provide		249			

Facility ID: 921849

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	-	D HUMAN SERVICES				FORM): 04/14/2024 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G227	B. WING		_	04/	10/2024
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
FLOWE D	RIVE GROUP HOME			28 FLOWE DRIVE CHARLOTTE, NC 2821	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	Continued From page while sitting at the din Review of records for	ing room table.	W 249				
	revealed an IHP dated review of the IHP reve client #3 to use the Bi finished" after eating a	d 12/19/23. Continued ealed a program goal for					
	C. The facility failed to program relative to us example:	o implement client #4's ing a Big Mac. For					
	7:06 AM revealed clie breakfast meal. Conti AM revealed client #4 and staff assisted the dishes. Further obser exited the kitchen and staff to brush her teet	roup home on 4/10/24 at nt #4 to participate in the nued observations at 7:13 to finish the breakfast meal client to the kitchen with her vations revealed the client went to the bathroom with n. Subsequent observations ne was staff observed to er Big Mac.					
	of the IHP revealed a	client #4 on 4/10/23 d 12/7/23. Continued review program goal for client #4 dicate "I'm finished" after					
		vith the QIDP confirmed that irrent. Continued interview ed that staff should					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 34G227 B. WING 04/10/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE FLOWE DRIVE GROUP HOME CHARLOTTE, NC 28213 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 12 W 249 W 249 implement the client's current goals. W 368 DRUG ADMINISTRATION W 368 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the system for drug administration failed to ensure all drugs were administered in compliance with physician orders for 4 of 5 clients (#1, #3, #4, and #5). The findings are: A. Observation on 4/10/24 at 7:45 AM revealed client #1 to enter the medication room with staff A. Continued observation revealed staff A to offer medications repeatedly to client #1 and client #1 to refuse the medications. Further observation at 8:05 AM revealed staff A to call staff D to the medication room and request that staff D administer the medications to client #1. Surveyor left the medication room in order to reduce stress on client #1, and subsequent observation revealed staff D to leave the medication room and report that client #1 had taken the meds. Record review on 4/10/24 revealed a physician's order for client #1 dated 2/8/24 which specifies that AM medications are to be administered at 7:00 AM. Interview with staff A, the home manager (HM), and the qualified intellectual disabilities professional (QIDP) on 4/10/24 confirmed that client #1's medication order is current and that all medications are to be administered within one hour of the prescribed administration time.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/14/2024

	-	ID HUMAN SERVICES				FORM): 04/14/2024 1 APPROVED
STATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G227	B. WING		_	04/	10/2024
NAME OF PF	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
FLOWE DI	RIVE GROUP HOME			628 FLOWE DRIVE CHARLOTTE, NC 2821	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 368	Continued From page	9 13	W 368	3			
	client #3 to enter the r A. Continued observa	0/24 at 8:36 AM revealed medication room with staff ation revealed client #3 to rom staff A and to leave the 41 AM.					
	order for client #3 date	0/24 revealed a physician's ed 3/22/24 which specifies are to be administered at					
	confirmed that client # current and that all me	HM, and QIDP on 4/10/24 #3's medication order is edications are to be ne hour of the prescribed					
	client #4 to enter the r A. Continued observa	10/24 at 9:38 AM revealed medication room with staff ition revealed staff D to room and report that client is.					
	order for client #4 date	0/24 revealed a physician's ed 2/8/24 which specifies are to be administered at					
	confirmed that client # current and that all me	HM, and QIDP on 4/10/24 #4's medication order is edications are to be ne hour of the prescribed					
	client #5 to enter the r A. Continued observa	10/24 at 9:16 AM revealed medication room with staff ition revealed staff D to room and report that client					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/14/2024 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	
		34G227	B. WING		04/	10/2024
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FLOWE D	RIVE GROUP HOME			28 FLOWE DRIVE HARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 368	Continued From page #5 had taken the med		W 368			
	order for client #5 date	0/24 revealed a physician's ed 9/5/23 which specifies are to be administered at				
	confirmed that client # current and that all me	HM, and QIDP on 4/10/24 #5's medication order is edications are to be ne hour of the prescribed				
W 474	administration policy of "Medication should all one (1) hour of the tim essential that a partice maintained in the block		W 474			
	developmental level of This STANDARD is n Based on observation interview, the facility f served in a form cons	not met as evidenced by: ns, record review and failed to ensure food was istent with the of 3 of 5 clients (#1, #3, and				
	A. The facility failed t consistency for client	o ensure appropriate diet #1. For example:				
	PM revealed the dinner hamburger, whole who	roup home on 4/9/24 at 5:07 er meal to include leat bread, salad, fries, and pservations revealed staff to				

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		ID HUMAN SERVICES				FORM A	04/14/2024 APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G227	B. WING			04/10	/2024	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, 2	ZIP CODE			
FLOWE D	RIVE GROUP HOME		628 FLOWE DRIVE CHARLOTTE, NC 28213					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		-	(X5) COMPLETION DATE	
W 474	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 474					

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	-	ID HUMAN SERVICES			FOR	D: 04/14/2024 M APPROVED	
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G227	B. WING		04	04/10/2024	
NAME OF P	ROVIDER OR SUPPLIER		STF	EET ADDRESS, CITY, STATE, ZIP CC	DE		
FLOWE D	RIVE GROUP HOME			FLOWE DRIVE ARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
W 474	Interview with the QIE confirmed client #3's interview with the QIE staff should ensure client diets. C. The facility failed for consistency for client Observations in the g PM revealed the dinn hamburger, whole wh and cranberry juice. C revealed staff to cut client bite size. Further obset to consume the dinner assistance to provide diet. Observations in the g 6:55 AM revealed the grits, diced bananas, milk. Continued obset assist client #4 to pro diet. Further observat the client bit her whol swallowing and staff of client to drink water. Review of records for revealed a nutritional Review of the nutritional Review of the nutritional Review of the nutritional Review with the QIE confirmed client #4's	DP and HM on 4/10/24 diet as current. Continued DP and HM confirmed that ients receive prescribed to ensure appropriate diet #4. For example: roup home on 4/9/24 at 5:04 er meal to include neat bread, fries, ketchup, Continued observations client #4's food consistent to ervations revealed client #4 er meal with no further the client with a chopped roup home on 4/10/24 at e breakfast meal to include a whole biscuit, water, and rvations revealed staff to not vide the client a chopped tions at 7:09 AM revealed e biscuit with difficulty continuously prompting the r client #4 on 4/10/24 evaluation dated 1/2023. nal evaluation for client #4 nt is prescribed a heart t, with double portions at	W 474				

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/14/2024 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
34G227		B. WING		04	04/10/2024		
NAME OF F	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE				
FLOWE DRIVE GROUP HOME				628 FLOWE DRIVE CHARLOTTE, NC 28213			
(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 ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE	
W 474	Continued From page staff should have prov chopped diet.		W 4				

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