PRINTED: 04/17/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G227	B. WING_	B. WING		04/	15/2025
	ROVIDER OR SUPPLIER RIVE GROUP HOME			628 FLOV	DDRESS, CITY, STATE, ZIP CODE VE DRIVE DTTE, NC 28213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 015	(1), §460.84(b)(1), §485 [(b) Policies and procedured policies and procedured plan set forth in paragasessment at paragand the communication this section. The policies reviewed and updefor LTC facilities]. At procedures must add (1) The provision of sand patients whether place, include, but are (i) Food, water, medical supplies (ii) Alternate sources following: (A) Temperatures to pasfety and for the safe provisions. (B) Emergency lighting (C) Fire detection, exapstems. (D) Sewage and was: *[For Inpatient Hospic Policies and procedures	.113(b)(6)(iii), §441.184(b) .82.15(b)(1), §483.73(b)(1), .542(b)(1), §485.625(b)(1) edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated every 2 years [annually a minimum, the policies and ress the following: ubsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical of energy to maintain the protect patient health and e and sanitary storage of ag. tinguishing, and alarm te disposal. ce at §418.113(b)(6)(iii):] res. additional requirements for atient care facilities only, redures must address the		015	TITLE		(X6) DATE

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

(X6) DATE

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G227	B. WING			04/15/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 628 FLOWE DRIVE CHARLOTTE, NC 28213)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 015	evacuate or shelter in limited to the followin (A) Food, water, med supplies. (B) Alternate sources following: (1) Temperatures to pasfety and for the safety and f	and patients, whether they in place, include, but are not g: lical, and pharmaceutical is of energy to maintain the corotect patient health and fe and sanitary storage of ing. Itinguishing, and alarm ite disposal. In the motivation of the provision is for clients and staff relative and water supply. The incliity's emergency food and individual four gallons of emergency.	EO	15			
E 037	adequate requiremen	nts.	E 03	37			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '		(X3) DATE SURVEY COMPLETED
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(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
§403.748(d)(1), §41 §441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §488 §485.727(d)(1), §488 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.19 at §484.102, REHs under §485.727, OF RHC/FQHCs at §49 (1) Training prograt the following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum preparedness trainii (iv) Demonstrate sta procedures. (v) If the emergency procedures are sign must conduct trainir procedures. *[For Hospices at §4 hospice must do all	16.54(d)(1), §418.113(d)(1), 80.84(d)(1), §482.15(d)(1), 8.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1), 85.920(d)(1), §486.360(d)(1), 8485.542, "Organizations" POs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness ures to all new and existing oviding services under rolunteers, consistent with their ency preparedness training at entation of all emergency ng. aff knowledge of emergency of preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following:	E 03	·	
	OVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From pa \$403.748(d)(1), \$46 \$441.184(d)(1), \$46 \$483.73(d)(1), \$48 \$485.68(d)(1), \$48 \$485.727(d)(1), \$48 \$491.12(d)(1). *[For RNCHIs at \$4 Hospitals at \$482.1 at \$484.102, REHs under \$485.727, OF RHC/FQHCs at \$49 (1) Training progra the following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at \$40 (i) Initial training in e policies and proced	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 \$403.748(d)(1), \$416.54(d)(1), \$418.113(d)(1), \$441.184(d)(1), \$460.84(d)(1), \$482.15(d)(1), \$483.73(d)(1), \$483.475(d)(1), \$484.102(d)(1), \$485.68(d)(1), \$485.542(d)(1), \$486.360(d)(1), \$491.12(d)(1). *[For RNCHIs at \$403.748, ASCs at \$416.54, Hospitals at \$482.15, ICF/IIDs at \$483.475, HHAs at \$484.102, REHs at \$485.542, "Organizations" under \$485.727, OPOs at \$486.360, RHC/FQHCs at \$491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at \$418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures.	OVIDER OR SUPPLIER RIVE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 \$403.748(d)(1), \$416.54(d)(1), \$418.113(d)(1), \$441.184(d)(1), \$460.84(d)(1), \$482.15(d)(1), \$483.475(d)(1), \$485.542(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.920(d)(1), \$486.360(d)(1), \$491.12(d)(1). *[For RNCHIs at \$403.748, ASCs at \$416.54, Hospitals at \$482.15, ICF/IIDs at \$483.475, HHAs at \$484.102, REHs at \$485.542, "Organizations" under \$485.727, OPOs at \$486.360, RHC/FQHCs at \$491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at \$418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures. *[For Hospices at \$418.113(d):] (1) Training. The hospice must do all of the following: (ii) Initial training in emergency preparedness policies and procedures to all new and existing	OVIDER OR SUPPLIER 34G227 STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213 PROVIDERS PLAN OF CORRE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 2 \$403.748(d)(1), \$416.54(d)(1), \$418.113(d)(1), \$483.73(d)(1), \$480.84(d)(1), \$482.15(d)(1), \$483.73(d)(1), \$483.475(d)(1), \$485.625(d)(1), \$485.8727(d)(1), \$485.920(d)(1), \$485.625(d)(1), \$485.727(d)(1), \$485.920(d)(1), \$485.625(d)(1), \$481.12(d)(1), \$480.348, ASCs at \$416.54, Hospitals at \$403.748, ASCs at \$416.54, Containing program. The [facility] must do all of the following: (i) Intital training in emergency preparedness training at least every 2 years. (iii) Provide emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. (V) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. (For Hospices at \$418.113(d); 1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness (V) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. (For Hospices at \$418.113(d); 1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness (ii) Irovide all of the following: (i) Initial training in emergency preparedness

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	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	•		
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E 037	procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revie emergency prepared employees (includin special emphasis play procedures necessation of the secondary of the second	ff knowledge of emergency fix now preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with acced on carrying out the ary to protect patients and entation of all emergency ng. preparedness policies and ifficantly updated, the hospice g on the updated policies and 1.184(d):] (1) Training must do all of the following: mergency preparedness ares to all new and existing viding services under plunteers, consistent with their ag, provide emergency ng every 2 years. Iff knowledge of emergency mentation of all emergency m	E 03	37			

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	ROVIDER OR SUPPLIER RIVE GROUP HOME			6	TREET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	staff, individuals provarrangement, contract volunteers, consisten (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain document (v) If the emergency procedures are signiff must conduct training procedures. *[For LTC Facilities at Program. The LTC fact following: (i) Initial training in ent policies and procedure staff, individuals provarrangement, and vole expected role. (ii) Provide emergence least annually. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, individuals staff, individuals procedures.	res to all new and existing iding on-site services under stors, participants, and the with their expected roles. The preparedness training at the following: In the	E	037			

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E 037	least every 2 years. (iii) Maintain docume (iv) Demonstrate star procedures. All new and assigned specific the CORF's emerge their first workday. To include instruction in alarm systems and sequipment. (v) If the emergence procedures are sign must conduct trainin procedures. *[For CAHs at §485.] The CAH must do all (i) Initial training in expolicies and procedure porting and exting and where necessar personnel, and guest cooperation with fire authorities, to all new individuals providing and volunteers, constroles. (ii) Provide emergence least every 2 years. (iii) Maintain docume (iv) Demonstrate star procedures. (v) If the emergence procedures are sign	cy preparedness training at entation of the training. If knowledge of emergency personnel must be oriented ic responsibilities regarding ncy plan within 2 weeks of the training program must at the location and use of signals and firefighting y preparedness policies and ifficantly updated, the CORF g on the updated policies and loft the following: mergency preparedness ures, including prompt uishing of fires, protection, y, evacuation of patients, its, fire prevention, and fighting and disaster	E 037			

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		34G227	B. WING _		0.	4/15/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	•		
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E 039	CMHC must provide preparedness policie and existing staff, incunder arrangement, with their expected redocumentation of the demonstrate staff knorocedures. Therease emergency prepared years. This STANDARD is Based on record reversiled to ensure direct the facility's Emerger (EPP) at least bienni. Review of the facility was updated on 3/20 revealed no evidence training on the EPP. Interview with the quiprofessional (QIDP) initial and biennial trabeen completed. EP Testing Requirem CFR(s): 483.475(d)(2), §482. §483.475(d)(2), §482. §485.542(d)(2), §483. §485.920(d)(2), §483. §485.920(d)(2), §483. §485.920(d)(2), §483. §485.542, OPO, "675. §485. §485. §485.542, OPO, "675. §485.	5.920(d):] (1) Training. The initial training in emergency is and procedures to all new dividuals providing services and volunteers, consistent oles, and maintain in training. The CMHC must owledge of emergency fter, the CMHC must provide in the training at least every 2 mot met as evidenced by: where the training are trained on the preparedness Plan ally. The finding is: "I's EPP on 4/14/25 revealed it in the training or biennial staff alified intellectual disabilities on 4/15/25 confirmed that alining for current staff has not ments	EO				

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E 039	(2) Testing. The [facto to test the emergence must do all of the following to the following to the following to the following to the factor of the emergence (A) When a community-based every 2 years (B) If the [facility natural or man-made activation of the emergence of the exempt from engagi community-based or functional exercise fractual event. (ii) Conduct an addity years, opposite the years, opposite years, opposite years, opposite years, opposite years, opposite years, opposit	Facilities at §494.62]: ility] must conduct exercises by plan annually. The [facility] lowing: Ill-scale exercise that is very 2 years; or nity-based exercise is not a facility-based functional ars; or y] experiences an actual exercise energency that requires ergency plan, the [facility] is ng in its next required individual, facility-based bollowing the onset of the ional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of cted, that may include, but is owing: ale exercise that is individual, facility-based or drill; or ise or workshop that is led by ides a group discussion using relevant emergency of problem statements, or prepared questions ge an emergency plan. lity's] response to and tion of all drills, tabletop gency events, and revise the	E 03		

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E 039	patient's home. The exercises to test the annually. The hospic (i) Participate in a ful community based ever (A) When a community based ever (B) If the hospice expranamed emergency plan, engaging in its next recommunity-based exfacility-based function onset of the emerger (ii) Conduct an addit opposite the year the exercise under paragis conducted, that may be to the following: (A) A second full-scar community-based or exercise; or (B) A mock disaster (C) A tabletop exercial facilitator and include a narrated, clinically-scenario, and a set of directed messages, of designed to challenger. (3) Testing for hospic care directly. The hoexercises to test the year. The hospice messages of the community based on the community based or the sercises to test the year. The hospice messages of the community based or the sercises to test the year. The hospice messages of the community based or the sercises to test the year.	B.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: Il-scale exercise that is cery 2 years; or certy based exercise is not an individual facility based every 2 years; or certences a natural or certences a natural or certences a natural or certences or individual scale ercise or individual nal exercise following the certency event. Conal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section and individual, but is not limited the exercise that is a facility based functional drill; or see or workshop that is led by des a group discussion using relevant emergency for problem statements, or prepared questions ean emergency plan. Les that provide inpatient spice must conduct emergency plan twice per	E	039			

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E 039	accessible, conduct facility-based function (B) If the hospice examan-made emergent the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disaste (C) A tabletop exert facilitator that including an emergency of the conduct exercises, and emergency and a set of problem essages, or prepare challenge an emergency (iii) Analyze the homaintain documents exercises, and emergency emergency is emergency emerge	d; or nity-based exercise is not an annual individual onal exercise; or experiences a natural or ney that requires activation of a, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. Itional annual exercise that not limited to the following: cale exercise that is or a facility based functional ar drill; or cise or workshop led by a des a group discussion using a relevant emergency scenario, an statements, directed ared questions designed to gency plan. Spice's response to and action of all drills, tabletop regency events and revise the exp plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must or test the emergency plan annual full-scale exercise that	EO	39		

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E 039	actual natural or mar requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emerger (ii) Conduct an and that may include following: (A) A second full-scale community-based or functional exercise; of (B) A mock (C) A tabletop endiscussion, using a remergency scenario statements, directed questions designed to plan. (iii) Analyze the maintain documentate exercises, and emergency scenario statements (2) Testing. The PACE at §460. (2) Testing. The PACE following: (i) Participate in an ais community-based; (A) When a community-based; (A) When a community-based; (A) When a community-based functions.	nal exercise; or spital, CAH] experiences an an-made emergency that if the emergency plan, the omengaging in its next ammunity based or individual, nal exercise following the ney event. [additional] annual exercise or a but is not limited to the lale exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is dincludes a group parrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency [facility's] response to and tion of all drills, tabletop gency events and revise the plan, as needed. 84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise is not an annual individual,	EO	39			

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E 039	Continued From pa	ge 11	E	039		
	man-made emerger the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct any ears opposite the exercise under parais conducted that me the following: (A) A second full-secommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challen (iii) Analyze the PAmaintain documentate exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency procedus (i) Participate in an is community-based (A) When a community-based (A) When a community-based functions are selected functions.	and the particle of the partic				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING _			04/15/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP 628 FLOWE DRIVE CHARLOTTE, NC 28213		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	requires activation of LTC facility is exem required a full-scale individual, facility-based following the onset of (ii) Conduct an add may include, but is (A) A second full-scommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-rand a set of probler messages, or prepachallenge an emerginal (iii) Analyze the [LT and maintain docun exercises, and emerginate [LTC facility] facility and the incommunity-based (i) Participate in an is community-based function (B) If the ICF/IID exercises and emergen the emergency planengaging in its next community-based of the incommunity-based of the incommunity-bas	in-made emergency that of the emergency plan, the pt from engaging its next community-based or ased functional exercise of the emergency event. itional annual exercise that not limited to the following: cale exercise that is a ran individual, facility based or a drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, a statements, directed ared questions designed to ency plan. IC facility] facility's response to mentation of all drills, tabletop argency events, and revise the semergency plan, as needed. 83.475(d)]: IIID must conduct exercises cy plan at least twice per year. To the following: annual full-scale exercise that all; or an annual individual, onal exercise; or. periences an actual natural or noty that requires activation of a, the ICF/IID is exempt from	E 0	39			

AND DI AN OF CODDECTION INDESTRUCTION NUMBER:		1 ` ′	IPLE CONSTRUCTION IG	(X:	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING _			04/15/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME		,	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	emergency event. (ii) Conduct an additional include, but is not (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/II maintain documentative exercises, and emerging ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a community-based function or. (B) If the HHA exercise for emergency event. (ii) Conduct an addition opposite the year the	onal annual exercise that of limited to the following: e exercise that is an individual, facility-based or rill; or the er workshop that is led by the a group discussion, cally-relevant emergency of problem statements, or prepared questions are an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the plan, as needed. 102] 114 HA must conduct exercises or plan at the HA must do the following: escale exercise that is the munity-based exercise is not an annual individual, and exercise every 2 years; experiences an actual natural ency that requires activation on, the HHA is exempt from equired full-scale individual, facility based the endividual, facility based the endividual, facility based the endividual on the endividual on the endividual on the endividual on the endividual of the endividual on the endividual of the endividual	EC	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED		
		34G227	B. WING			04/15/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	Continued From pag	e 14 at may include, but is not	E 03	39			
	community-based or functional exercise; (C) A mock disas (C) A tabletop exercise; (C) A tabletop exercise; (C) A tabletop exercise in the control of a facilitator and discussion, using a remergency scenario statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all emergency events, as emergency plan, as the control of the control	an individual, facility-based or ster drill; or sercise or workshop that is d includes a group sarrated, clinically-relevant, and a set of problem messages, or prepared o challenge an emergency 's response to and maintain drills, tabletop exercises, and and revise the HHA's needed.					
	(d)(2) Testing. The Oto test the emergence following: (i) Conduct a paper-laworkshop at least an led by a facilitator and discussion, using a remergency scenario statements, directed questions designed to plan. If the OPO expended emergency plan, engaging in its next of following the onset of (ii) Analyze the OPO documentation of all	pPO must conduct exercises y plan. The OPO must do the pased, tabletop exercise or nually. A tabletop exercise is d includes a group parrated, clinically relevant and a set of problem messages, or prepared o challenge an emergency periences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. Its response to and maintain tabletop exercises, and and revise the [RNHCI's and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING		04/15/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		
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E 039	Continued From page	: 15	E 03	9		
	must do the following (i) Conduct a paper-b least annually. A table discussion led by a fa clinically-relevant emo of problem statement prepared questions d emergency plan. (ii) Analyze the RNHO maintain documentati and emergency event emergency plan, as n This STANDARD is r Based on record revi failed to conduct bien	AHCI must conduct emergency plan. The RNHCI cased, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, is, and revise the RNHCI's				
	table top exercise dat revealed no evidence	s EPP on 4/14/25 revealed a ed 3/6/25. Continued review of an additional full-scale sed exercise or mock drill				
W 104	professional (QIDP) of facility has not condu- community/facility-base exercise. GOVERNING BODY CFR(s): 483.410(a)(1		W 10	4		
		nust exercise general policy, g direction over the facility.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING	·····	04	/15/2025	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
W 104	Based on observations governing body faile budget, and operation relative to hygiene since the bathrooms. Continue the survey revealed the bathroom without further observations to provide body was washing before mean linterview with the quiprofessional (QIDP) clients should have a bathrooms. PROTECTION OF CCFR(s): 483.420(a)() The facility must ensity treatment and care of the continuent of the facility was maintained for the continuent was a client #4 was observed with one staff and or wash her hands priodobservations revealed she needed to use the continuent in the continuent in the continuent was the continuen	not met as evidenced by: ons and interview, the d exercise general policy, g direction over the facility upplies. The finding is: hout the 4/14-15/25 survey to be unavailable in the client ed observations throughout clients to independently use t access to hand soap. at meal time revealed staff in to support clients with hand ds. alified intellectual disabilities on 4/15/25 confirmed all access to hand soap in the CLIENTS RIGHTS 7) ure the rights of all clients. y must ensure privacy during of personal needs. not met as evidenced by: on, record review and failed to ensure that privacy of 6 clients (#4). The finding in the home on 4/14/25, ed to enter a restroom along te other client in order to	W 10				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G227	B. WING			04/	15/2025
	ROVIDER OR SUPPLIER		1	6	TREET ADDRESS, CITY, STATE, ZIP CODE 28 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 130	and the door to the re Interview with the qua professional (QIDP) of	e 17 remained in the restroom estroom remained open. alified intellectual disabilities on 4/15/25 confirmed all staff ' privacy is protected during	w	130			
W 249	personal care and tre PROGRAM IMPLEMI CFR(s): 483.440(d)(1	atment. ENTATION	W	249			
	each client must rece treatment program co interventions and serv and frequency to sup	ndividual program plan, ive a continuous active					
	Based on observatio interviews, the facility clients (#4) received a treatment program as Person-Centered Plan	identified in the n (PCP) relative to use of a nd staff implementation of					
	on 4/14/25, client #4 v individual activities ar consisted of beef ravi free pudding. Further during the dinner mea #4 to put her fork dow	vations in the group home was observed to take part in a to eat dinner which oli, green beans, and sugar observations revealed that al, no staff prompted client on after each bite of food sumed her meal rapidly and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G227	B. WING _			04/15/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME		1	STREET ADDRESS, CITY, STATE, ZIP COL 628 FLOWE DRIVE CHARLOTTE, NC 28213	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 249	observation revealed table and take her of Subsequent observation that was plant dinner table, but the switch, nor was she by any staff. During morning obsorvation to redirect client #4 #4 refused. Continued to eventually allocoffee, but at no tinued to use a Big Mack's Subsequent observation to the discovery take part in the bread consume her meal meal was client #4 down after each bit observation revealed table and take her cobservation revealed placed at client #4 south that client #	ge 18 fork down. Continued ed client #4 to get up from the dishes to the kitchen. ration revealed a Big Mack ced at client #4's place at the at client #4 never used the e prompted to use the switch servations in the group home 4 was observed to indicate f that she wanted coffee. Its revealed staff C to attempt to the living room, but client ated observation revealed staff we client #4 to prepare a cup of the did staff C prompt client #4 switch to request her coffee. Itation revealed client #4 to takfast meal which consisted of the area, prune juice and milk. The prompted to put her spoon the of food. Additional the dishes to the kitchen. Finally, the da Big Mack switch that was to place at the breakfast table, the swer used the switch, nor was the time the switch by any staff.	W 2				
	dated 10/7/24 whic goals as, "Use a Bi finished' after eating verbal prompts," "U request 'Please' wh	revealed a PCP for client #4 h lists some of client #4's g Mack switch to indicate 'I'm g a meal with no more than 2 lse a Big Mack switch to en she would like to make her e than 2 verbal prompts," and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G227	B. WING			04/	15/2025
	ROVIDER OR SUPPLIER			62	TREET ADDRESS, CITY, STATE, ZIP CODE 28 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
W 249	Interview with the quaprofessional (QIDP) of staff should have professional to the	after each bite of food with all prompts." Alified intellectual disabilities on 4/15/25 confirmed that impted client #4 to use the witches and to put her utensil of food. TION TION administration must assure ing those that are administered without error. In our met as evidenced by: n, record review and failed to ensure that all ite that are self-administered, thout error for 1 of 6 clients to up home on 4/15/25 at 6:30 in the inued observation at 7:45 in the inued observation at 7:45 in the inued observation at 7:45 in the inued observation pass in the following two sulfate - 15 mL dose on cup by Staff B and taken	W				
		record on 4/15/25 revealed ted 3/19/25. Review of the					

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G227	B. WING			04/	15/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (628 FLOWE DRIVE CHARLOTTE, NC 28213	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
W 472	Iron (75mg)/mL Oral Iby oral route; Tirosint Solution - Take 1 mL morning at least 30 m Interview with Staff B administered a 15 mL client #2. Interview wid 4/15/25 confirmed clie orders are current. Colient #2 received the Sulfate. Further interviews hould have received minutes before break MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served This STANDARD is reported in the approprior clients (#1, #2, #3 and Observations in the gouring the evening maserved beef ravioli, grounding. Further obset to be served family strusted to assist clients plates. The serving simenu were 4 oz. of ra and ½ cup of pudding revealed all clients reportions of ravioli and	e: Ferrous Sulfate 15 mg Drops - Take 1 mL every day -SoL 62.5 mcg/mL Oral by mouth daily in the ninutes before breakfast. on 4/15/25 verified they dose of Ferrous Sulfate to ith the facility nurse on ent #2's AM medication ontinued interview confirmed incorrect dose of Ferrous view confirmed client #2 the Tirosint Solution 30 fast as prescribed. (2)(i) in appropriate quantity not met as evidenced by: ns, record reviews and failed to ensure food was iate quantity for 4 of 6 d #5). The findings are: roup home on 4/14/25 eal revealed all clients to be reen beans and sugar free ervation revealed the meal tyle, with no measuring tools with portioning food on their zes indicated on the daily avioli, ½ cup of green beans, g. Subsequent observation	W	472			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING		0	4/15/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 628 FLOWE DRIVE CHARLOTTE, NC 28213	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 E APPROPRIATE	(X5) COMPLETION DATE	
W 472	during breakfast rever Cream of Wheat cern observation revealed family style with clier serve themselves the Subsequent observation made by staff to meat themselves and the larger or smaller that individually prescribed Review of client #1's a nutritional evaluation indicates client #1's meats, double portion Review of client #2's a nutritional evaluation indicates client #2's meats, double portion Review of client #3's a nutritional evaluation indicates client #5's a nutritional evaluation indicates client #5's a nutritional evaluation indicates client #5's healthy, chopped as all meals. Interview with the quiprofessional (QIDP) clients' prescribed di interview with the QI	group home on 4/15/25 ealed all clients to be served eal and prune juice. Further if the meal to again be served ints using a large spoon to e Cream of Wheat cereal. Itions revealed no effort asure the food clients served servings appeared to be in called for by clients' ed diets. Trecord on 4/15/25 revealed for dated 2/11/25 which prescribed diet to be chopped on dated 2/11/25 which prescribed diet to be chopped on dated 2/11/25 which prescribed diet to be chopped on at all meals. Trecord on 4/15/25 revealed on dated 2/11/25 which prescribed diet to be regular, record on 4/15/25 revealed on dated 2/11/25 which prescribed diet to be regular, record of starch and desserts,	W 472				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING _			04/15/2025
	ROVIDER OR SUPPLIER RIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP 628 FLOWE DRIVE CHARLOTTE, NC 28213	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 472	Continued From pag prescribed.	e 22	W 4	.72		