PRINTED: 04/28/2025 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		34G141	B WING			cn.
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 FRANKLIN BLVD GASTONIA, NC 28054	RECEIV	04/24/2025
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	CFR(s): 483.475(d)(2) §416.54(d)(2), §418.1: §460.84(d)(2), §482.1: §483.475(d)(2), §484 §485.542(d)(2), §485 *[For ASCs at §416.54 at §485.542, OPO, "Or §485.727, CMHCs at § §491.12, and ESRD Fa (2) Testing. The [facility to test the emergency product and the following accessible, conduct a freezercise every 2 years; (B) If the [facility] enatural or man-made error activation of the emergency product and the following accessible activation of the emergency product and the following activation of the emergency product and the following activation of the emergency productional exercise followers, opposite the year functional exercise under the following activation of the following activ	13(d)(2), §441.184(d)(2), 55(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 525(d)(2), §485.68(d)(2), 12(d)(2), §494.62(d)(2). CORFs at §485.68, REHs ganizations" under (485.920, RHCs/FQHCs at acilities at §494.62]: If must conduct exercises blan annually. The [facility] wing: Cale exercise that is y 2 years; or y-based exercise is not acility-based functional or experiences an actual mergency that requires ency plan, the [facility] is n its next required dividual, facility-based wing the onset of the lat exercise at least every 2 of the full-scale or exparagraph (d)(2)(i) of did, that may include, but is necessarily exercise that is ividual, facility-based		*[For ICF/IIDs at §483.475(d)]: Springdale Group Home will part the pre-scheduled annual full-scafacility-based evacuation drill on 2025, to fulfill the required emerge exercise for the current year. All staff will participate and the expedition become the documented and analyzed by Safety and QA/QI committee as right as a full review of emergen preparedness participation logs a reports for the previous 12 months determine to determine any other testing and training. The Safety and Risk Manager will formal Emergency Preparedness Schedule. The schedule will be reand approved by the Safety and Quemmittee, added to the QA/QI Performance Improvement calend enforced by the ICF Clinical Direct Operations Manager. The Safety and Risk Manager as we have Safety Committee is now responsible. -Verifying alternate annual exercises completed. -Verifying whether an actual emerge exempts the facility from one of the required exercises. -Documenting all exercises and ensithat after-action reviews are completed and stored.	ale, May 21st, ency ercise will the equired. I ncy nd s to lapses in create a Testing viewed AA/QI ar, and for and vell as onsible es are gency suring	06/23/2025

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 F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	ECONSTRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY MPLETED
NAME OF S	DROVIDED OF CURRILIES	34G141	B. WING)4/24/2025
Quitestre	PROVIDER OR SUPPLIER N GROUP HOME SUMMARY STA	STEMENT OF DEFICIENCIES	1 0	STREET ADDRESS, CITY, STATE, ZIP CODE 101 FRANKLIN BLVD GASTONIA, NC 28054		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	a facilitator and includ a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facility maintain documentation exercises, and emerge [facility's] emergency patient's home. The heavercises to test the erannually. The hospice (i) Participate in a full-tecommunity based even (A) When a community accessible, conduct an functional exercise eve (B) If the hospice experiman-made emergency the emergency plan, the engaging in its next requommunity-based exercises under paragral is conducted, that may it to the following: (A) A second full-scale community-based or a fexercise; or B) A mock disaster drill C) A tabletop exercise	es a group discussion using elevant emergency problem statements, prepared questions an emergency plan. (*s] response to and on of all drills, tabletop ency events, and revise the elan, as needed. 113(d):] s that provide care in the espice must conduct energency plan at least must do the following: escale exercise that is y 2 years; or based exercise is not individual facility based by 2 years; or elences a natural or energency plan at least must do the following: escale exercise is not individual facility based by 2 years; or elences a natural or energency plan at least must do the following that requires activation of the hospital is exempt from uired full scale exercise following the event. (*elevanta exercise every 2 years, elescale or functional on (d)(2)(i) of this section include, but is not limited exercise that is eacility based functional	E 039	Staff training on emergency prepared requirements under §483.475 will be scheduled quarterly and added to the annual training curriculum. The facility's QA/QI Committee will review documentation of all emergency exercises and real events quarterly. A compliance checklist will be maintain by the ICF Clinical Director and Operations Manager and submitted to Safety Committee and QA/QI committed quarterly. Any missed or incomplete exercise will trigger a 30-day corrective period, duri which the required exercise must be conducted.	ned the ee	06/23/25

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DAT	IO. 0938-0391 TE SURVEY MPLETED
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FRANKLI	PROVIDER OR SUPPLIER N GROUP HOME		1101	EET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN BLVD STONIA, NC 28054	1 04	4/24/2025
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	directed messages, of designed to challenge (3) Testing for hospic care directly. The hospic exercises to test the expear. The hospice may be a community-based; (A) When a community-based; (A) When a community-based function (B) If the hospice experimental emergency plan, the emergency plan in the plan between the emergency plan and the plan between the p	relevant emergency of problem statements, or prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or ty-based exercise is not in annual individual isal exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community of functional exercise the emergency event. Initial annual exercise that it limited to the following: e exercise that is facility based functional rill; or e or workshop led by a a group discussion using a vant emergency scenario, tatements, directed di questions designed to cy plan. De's response to and of all drills, tabletop ncy events and revise the	E 039			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
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	*[For PRFTs at §441 §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or manrequires activation of [facility] is exempt from the first of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scale community-based or infunctional exercise; or (B) A mock discussion, using a naise mergency scenario, a statements, directed may be a facility analyze the [fanalitain documentation and community functional exercise].	\$485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must must for the emergency plan properties and the emergency expressed exercise is not an annual individual, and exercise; or coital, CAH] experiences and emergency that the emergency plan, the emergency plan, the mengaging in its next munity based or individual, and exercise following the expressed exercise that is individual, and exercise that is individual, a facility-based exercise that is includes a group trated, clinically-relevant and a set of problem essages, or prepared challenge an emergency cility's] response to and more all drills, tabletop may events and revise the tan, as needed.	E 039	DETICIENCE T)		

PRINTED: 04/28/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	IES V	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
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PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
exercises to annually. To following: (i) Participal is community facility-based (B) If the PARTICIPATE engaging in based or incompart exercise following (A) A second community-to functional exercise in a facilitator a using a narral scenario, and directed mes designed to compart (iii) Analyze maintain doce exercises, an PACE's emer	The PAC of test the end test the end test the end test in an and ty-based; community conduct a end function to Experiment test test test test test test test t	E organization must conduct emergency plan at least organization must do the innual full-scale exercise that or y-based exercise is not in annual individual, all exercise; or ences an actual natural or y that requires activation of the PACE is exempt from quired full-scale community cility-based functional conset of the emergency ditional exercise every 2 or the full-scale or functional aph (d)(2)(i) of this section include, but is not limited to exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is dividual, a facility based ill; or exercise that is led by a group discussion, ally-relevant emergency plan. In emergency plan. It is response to and in of all drills, tabletop incorporate questions and revise the in, as needed.	E 039			

AND	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA1	IO. 0938-0391 TE SURVEY MPLETED
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PI	KEFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E	emergency proced ICF/IID] must do the community-base (A) When a community-base (A) When a community-based function (B) If the [LTC facility-based function LTC facility is exemined a full-scale individual, facility-based functional the community-based of community-based	ry plan at least twice per year, inced staff drills using the dures. The [LTC facility, ne following: In annual full-scale exercise that ed; or unity-based exercise is not contain annual individual, income exercise. Ity] facility experiences an an-made emergency that of the emergency plan, the not from engaging its next experiences of the emergency event. In the interest of the emergency event is a group discussion, using a elevant emergency scenario, in statements, directed red questions designed to ency plan. C facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. In the interest twice per year in the following: IID must conduct exercises y plan at least twice per year.	E 039			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA (X2) M		1.00		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER		1101	EET ADDRESS, CITY, STATE, ZIP CODE FRANKLIN BLVD STONIA, NC 28054	1 04	4/24/2025
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(to let	is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID experimental emergency plan, the emergency plan, the emergency plan, the emergency plan, the emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster dr. (C) A tabletop exercise a facilitator and include using a narrated, clinic scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/IID maintain documentation exercises, and emerge ICF/IID's emergency plantal exercises, and emergency plantal exercises exercises.	or ty-based exercise is not an annual individual, hal exercise; or. eriences an actual natural or y that requires activation of the ICF/IID is exempt from equired full-scale ndividual, facility-based lowing the onset of the anal annual exercise that t limited to the following: e exercise that is an individual, facility-based will; or e or workshop that is led by es a group discussion, hally-relevant emergency problem statements, prepared questions an emergency plan. O's response to and of all drills, tabletop ncy events, and revise the an, as needed. 21 A must conduct exercises blan at A must do the following: cale exercise that is unity-based exercise is not	E 039			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	71
		34G141	B. WING		04/24/2025	
FRANKLI	PROVIDER OR SUPPLIER N GROUP HOME		110	REET ADDRESS, CITY, STATE, ZIP CODE 11 FRANKLIN BLVD ISTONIA, NC 28054	04/24/2025	Parliament
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	or man-made emerge of the emergency platengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paragris conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disast (C) A tabletop exelled by a facilitator and discussion, using a nate emergency scenario, a statements, directed in questions designed to plan. (iii) Analyze the HHA's documentation of all disemergency events, and emergency plan, as not emergency plan, as not emergency following: (i) Conduct a paper-base workshop at least annual ed by a facilitator and endorse the emergency endorse end	experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based flowing the onset of the enal exercise every 2 years, full-scale or functional example (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay include, but is not graph (d)(2)(i) of this section enay includes a group enay include exercises or graph enay includes a group enay include	E 039			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/28/2025 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A. BUILDING COMPLETED 34G141 B. WING 04/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 FRANKLIN BLVD FRANKLIN GROUP HOME GASTONIA, NC 28054 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 039 Continued From page 8 E 039 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's Emergency Preparedness Plan (EPP). The finding is:

mock drill exercise.

Review of the facility's EPP on 4/23/25 revealed a table top exercise dated 3/11/24. Continued review revealed no evidence of an additional full-scale community/facility-based exercise or

Interview with the qualified intellectual

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RANKLIN GROUP HOME			1101 FRANKLIN BLVD GASTONIA, NC 28054		
(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) COMPLETIC DATE	
E 039	Continued From page 9 developmental professional (QIDP) on 4/24/25 confirmed the facility has not conducted an additional full-scale community/facility-based exercise or mock drill exercise. Further interview with the QIPD revealed there's one scheduled for 5/2025.	E 039			

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