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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		34G227	B. WING		0445	(000=	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213			04/15/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
E 015	CFR(s): 483.475(b)(§403.748(b)(1), §418	1) 3.113(b)(6)(iii), §441.184(b)	E 015				
	§483.475(b)(1), §485	482.15(b)(1), §483.73(b)(1), 5.542(b)(1), §485.625(b)(1)			(m)		
	develop and impleme policies and procedur plan set forth in parag assessment at parag and the communication this section. The poli- be reviewed and update	cedures. [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:		OHSR-MH LICE			
	and patients whether place, include, but are (i) Food, water, medic supplies (ii) Alternate sources of following: (A) Temperatures to p	ubsistence needs for staff they evacuate or shelter in e not limited to the following: eal and pharmaceutical of energy to maintain the protect patient health and e and sanitary storage of					
	(B) Emergency lighting (C) Fire detection, ext systems. (D) Sewage and waste	inguishing, and alarm					
1	Policies and procedure (6) The following are a hospice-operated inpa The policies and proce following: (iii) The provision of su	dditional requirements for atient care facilities only. Edures must address the					

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.

4-24-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
4		34G227	B. WING		04/	15/2025
	OVIDER 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 APPRO DÉFICIENCY)	LD BE	(X5) COMPLETION DATE
E 015	evacuate or shelter i limited to the followin (A) Food, water, me supplies. (B) Alternate source following: (1) Temperatures to safety and for the saprovisions. (2) Emergency lighti (3) Fire detection, experiments of the sample of the sampl	and patients, whether they in place, include, but are not ing: dical, and pharmaceutical is of energy to maintain the protect patient health and afe and sanitary storage of ing. ktinguishing, and alarm	E 018	The group home manager monthly checks to ensure food and water supplies manager equirements and make the food items are not out of dwill follow up with Group manager quarterly to ensuremergency items are being monitored.	that the eet the at all late. Qp home re	6/1/2025
E 037	water supply on 4/14 food items dating be observation revealed water. Review of the facilit 4/14/25 revealed eight to meet the emerger Interview with qualifyrofessional (QIDP emergency food an inspected regularly adequate requirem	fied intellectual disabilities) on 4/15/25 confirmed the d water supply should be to ensure all items meet the ents.	E 03	37		
	CFR(s): 483.475(d)					

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			04/15/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 628 FLOWE DRIVE CHARLOTTE, NC 28213	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 037	§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 §482.13; at §484.102, REHs under §485.727, OF RHC/FQHCs at §49; (1) Training progratthe following: (i) Initial training in epolicies and procedistaff, individuals programment, and very expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain documpreparedness training (iv) Demonstrate state procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at §4 hospice must do all of items and procedures	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), 8486.360(d)(1), 8486.360(d)(1), 8486.360(d)(1), 8486.360, 848	E 03			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING		04/15/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 328 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSE DÉFICIENCY)	D BE COMPLETION	
E 037	procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revide emergency prepared employees (includin special emphasis play procedures necessations). (v) Maintain docume preparedness training (vi) If the emergency procedures are sign must conduct training procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in expolicies and procedures and procedures and procedures and procedures. (ii) After initial training preparedness training preparedness training preparedness training preparedness training preparedness training emergency area of the second procedures.	f knowledge of emergency acy preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and entation of all emergency ag. y preparedness policies and ificantly updated, the hospice g on the updated policies and ificantly updated policies and and the	E 037			
	(iv) Maintain docum preparedness traini (v) If the emergency procedures are sign must conduct training procedures. *[For PACE at §460 organization must described to the control of the c	entation of all emergency ng. y preparedness policies and ifficantly updated, the PRTF ng on the updated policies and 1.84(d):] (1) The PACE to all of the following:				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING		04/15/2025	
ANNA CANA CANA CANA CANA CANA CANA CANA	ROVIDER OR SUPPLIER RIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMPLÉTION	
E 037	policies and procedustaff, individuals provarrangement, contravolunteers, consister (ii) Provide emergent least every 2 years. (iii) Demonstrate staprocedures, includin what to do, where to case of an emergency (iv) Maintain docume (v) If the emergency procedures are signimust conduct training procedures. *[For LTC Facilities at Program. The LTC fafollowing: (i) Initial training in expolicies and procedustaff, individuals provarrangement, and voexpected role. (ii) Provide emergency least annually. (iii) Maintain docume preparedness training (iv) Demonstrate starprocedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, incompared training staff, incomparedness policies and existing staff, incompared training staff, incompared train	ares to all new and existing viding on-site services under ctors, participants, and int with their expected roles. Cy preparedness training at the first of go, and whom to contact in cy. Internation of all training. In preparedness policies and ficantly updated, the PACE go in the updated policies and actility must do all of the internation of all emergency preparedness res to all new and existing viding services under allunteers, consistent with their cy preparedness training at intation of all emergency go. If knowledge of emergency go.	E 03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED .	
•		34G227	B. WING	1 - Annual and a second	0-	4/15/2025
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 037	(ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned specthe CORF's emerging their first workday, include instruction alarm systems and equipment. (v) If the emergen procedures are sigmust conduct training procedures. *[For CAHs at §488] The CAH must docional training in policies and procedures and where necess personnel, and gue cooperation with finauthorities, to all not individuals providing and volunteers, coroles. (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate sprocedures. (v) If the emerger procedures are signocedures are signocedures are signocedures are signocedures are signocedures are signocedures.	nertation of the training. aff knowledge of emergency by personnel must be oriented ific responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and inificantly updated, the CORF ing on the updated policies and a 5.625(d):] (1) Training program. all of the following: emergency preparedness dures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and refighting and disaster ew and existing staff, ing services under arrangement, insistent with their expected	E	037		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
34G227	B. WING		04	/15/2025	
		628 FLOWE DRIVE		13/2023	
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
§485.920(d):] (1) Training. The vide initial training in emergency plicies and procedures to all new f, individuals providing services ent, and volunteers, consistent ed roles, and maintain f the training. The CMHC must f knowledge of emergency treafter, the CMHC must provide aredness training at least every 2 is not met as evidenced by: review and interview, the facility direct care staff were trained on regency Preparedness Plan eminially. The finding is: ility's EPP on 4/14/25 revealed it 6/20/25. Continued review ence of initial or biennial staff erp. qualified intellectual disabilities P) on 4/15/25 confirmed that a training for current staff has not rements d)(2). 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.625(d)(2), §485.68(d)(2), 485.625(d)(2), §485.68(d)(2), 66.54, CORFs at §485.68, REHs b, "Organizations" under	E 039	Qp will in-service the Emergency Preparedne Evacuation plan annua	ess Illy. Qp will	6/1/2025	
	IDENTIFICATION NUMBER:	A BUILDING 34G227 B. WING PREFIX TAG PREFIX TAG B. WING PREFIX TAG B. WING PREFIX TAG B. WING PREFIX TAG PREFIX TAG B. WING PREFIX TAG PREFIX TAG	R E STREET ADDRESS. CITY, STATE, ZIP COD 628 FLOWE DRIVE CHARLOTTE, NC 28213 PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION) PAGE SASS. 20(d):] (1) Training. The vide initial training in emergency plicies and procedures to all new fi, individuals providing services ent, and volunteers, consistent ed roles, and maintain if the training. The CMHC must ff knowledge of emergency reafter, the CMHC must provide are denses training at least every 2 and interview, the facility lirect care staff were trained on rgency Preparedness Plan enmially. The finding is: Illity's EPP on 4/14/25 revealed it 8/20/25. Continued review ence of initial or biennial staff PP. qualified intellectual disabilities PP on 4/15/25 confirmed that I training for current staff has not ements d)(2) 18.113(d)(2), §443.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.625(d)(2), §485.68(d)(2), 485.625(d)(2), §485.68(d)(2), 485.625(d)(2), §485.68, REHs , "Organizations" under	IDENTIFICATION NUMBER 34G227 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213 D. PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE PRECEDED BY FULL YOR I.S. IDENTIFYING INFORMATION) PAGE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213 D. PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE PREMINED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE PREMINED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-ARE PREMINED TO THE APPROPRIATE DEFICIENCY) QP will in-service the staff on the Emergency Preparedness Evacuation plan annually. Qp will document training in In-service book for records. E 037 QP will in-service the staff on the Emergency Preparedness Evacuation plan annually. Qp will document training in In-service book for records. E 038 It in not met as evidenced by: review and interview, the facility lirect care staff were trained on regency Preparedness Plan minially. The finding is: Ility's EPP on 4/14/25 revealed it 1/20/25. Continued review mone of initial or biennial staff PP. qualified intellectual disabilities P) on 4/15/25 confirmed that I training for current staff has not ements d(X)2) 18.113(d)(2), §481.184(d)(2), 22.15(d)(2), §485.68(d)(2), 485.62(d)(2), §485.68(d)(2), 485.62(d)(2), §485.68, REHs , "Organizations" under	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B WING			1/15/2025
	ROVIDER OR SUPPLIER	628 FLOWE DRIVE			DE	
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DÉFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	(2) Testing. The [far to test the emergen must do all of the formust do all of the formu	cility] must conduct exercises cy plan annually. The [facility] sillowing: ull-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ears; or ty] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based e following the onset of the dittional exercise at least every 2 e year the full-scale or e under paragraph (d)(2)(i) of ducted, that may include, but is collowing: scale exercise that is or individual, facility-based e; or	E 039			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G227	B. WING			04/15/2025
	ROVIDER OR SUPPLIER RIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COL 628 FLOWE DRIVE CHARLOTTE, NC 28213	Œ	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 039	patient's home. The exercises to test the annually. The hosp (i) Participate in a community based of (A) When a community based of (A) When a community based of (A) When a community based of (B) If the hospice of the emergency planengaging in its next community-based of facility-based functionset of the emerge (ii) Conduct an addropposite the year the exercise under parties conducted, that into the following: (A) A second full-second community-based of exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or a facilitator and inclusion and a set directed messages designed to challer (3) Testing for hospicare directly. The intexercises to test the year. The hospice	pices that provide care in the e hospice must conduct e emergency plan at least pice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not an individual facility based every 2 years; or experiences a natural or not that requires activation of the hospital is exempt from a required full scale exercise or individual conal exercise following the ency event. In the full-scale or functional exercise every 2 years, the full-scale or functional exercise exercise is not the full-scale or functional exercise every 2 years, the full-scale or functional exercise that is or a facility based functional	E 039			

		IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION		(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	DE	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR 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	
E 039	accessible, conduction facility-based function (B) If the hospice of man-made emergency platengaging in its new based or facility-based or facility-based or facility-based (ii) Conduct an admay include, but is (A) A second full-community-based exercise; or (B) A mock disast (C) A tabletop exercise facilitator that inclunarrated, clinically and a set of problemessages, or prependation of the maintain documer exercises, and emergency in the formation of the second facility and a set of problemessages.	and; or unity-based exercise is not et an annual individual tional exercise; or experiences a natural or ency that requires activation of in, the hospice is exempt from t required full-scale community ased functional exercise t of the emergency event. ditional annual exercise that is not limited to the following: escale exercise that is or a facility based functional er drill; or ercise or workshop led by a ides a group discussion using a erelevant emergency scenario, em statements, directed bared questions designed to	EO	39			
	§482.15(d), CAHs (2) Testing. The [If conduct exercises twice per year. The dothe following: (i) Participate in a is community-bas (A) When a community-bas	PRTF, Hospital, CAH] must to test the emergency plan he [PRTF, Hospital, CAH] must n annual full-scale exercise that			,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDII		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G227	B. WING _			04/15/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 628 FLOWE DRIVE CHARLOTTE, NC 28213	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
	actual natural or man requires activation of [facility] is exempt fro required full-scale con facility-based function onset of the emergen (ii) Conduct an [a and that may include, following: (A) A second full-scale community-based or in functional exercise; on (B) A mock of (C) A tabletop existed by a facilitator and discussion, using a newergency scenario, statements, directed in questions designed to plan. (iii) Analyze the [filmaintain documentative exercises, and emergency [facility's] emergenc	nal exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next munity based or individual, nal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is ndividual, a facility-based r lisaster drill; or ercise or workshop that is lincludes a group arrated, clinically-relevant and a set of problem messages, or prepared challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. (d):] corganization must conduct mergency plan at least or y-based exercise is not annual full-scale exercise that or y-based exercise is not annual individual,	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•	34G227	B. WING		04/15/20	25
NAME OF PROVIDER OR SUPPLIER FLOWE DRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	-	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
the emergency plan, engaging in its next re based or individual, fexercise following the event. (ii) Conduct an anyears opposite the years opposite the years conducted that man the following: (A) A second full-scatcommunity-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clin scenario, and a set of directed messages, of designed to challeng (iii) Analyze the PAC maintain documentate exercises, and emergency procedured in the following unannounce emergency procedured in the following unannounce emergency procedured in an anis community-based; (A) When a community-based; (A) When a community-based functions.	cy that requires activation of the PACE is exempt from equired full-scale community actility-based functional e onset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section y include, but is not limited to ale exercise that is individual, a facility based or drill; or ise or workshop that is led by des a group discussion, itically-relevant emergency of problem statements, or prepared questions e an emergency plan. CE's response to and tion of all drills, tabletop gency events and revise the plan, as needed. at §483.73(d):] must conduct exercises to plan at least twice per year, and staff drills using the res. The [LTC facility, following: annual full-scale exercise that is or ity-based exercise is not an annual individual,	E 038			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		34G227				04/15/2025	
	PROVIDER OR SUPPLIER			628 F	ET ADDRESS, CITY, STATE, ZIP CODE LOWE DRIVE RLOTTE, NC 28213		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	actual natural or man- requires activation of the LTC facility is exempt required a full-scale or individual, facility-base following the onset of (ii) Conduct an additionary include, but is not (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-releand a set of problem is messages, or prepare challenge an emergen (iii) Analyze the [LTC facility] facility's exercises, and emerge [LTC facility] facility's exercises, and emerge [LTC facility] facility's exercises in an annis community-based; of (A) When a community accessible, conduct an facility-based functional (B) If the ICF/IID experiman-made emergency	the emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. It imited to the following: the exercise that it limited to the following: the exercise that is an individual, facility based or event emergency scenario, tatements, directed differency events, and revise the emergency scenario, tatements, directed differency events, and revise the emergency plan. Facility facility's response to the emergency plan, as needed. 475(d)]: Differency must conduct exercises plan at least twice per year, the following:	E	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED		
		34G227	B. WING		04/15/2025	
	ROVIDER OR SUPPLIER		628 F	ET ADDRESS, CITY, STATE, ZIP CODE LOWE DRIVE RLOTTE, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DÉFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	emergency event. (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise (B) A mock disaste (C) A tabletop exer a facilitator and incusing a narrated, c scenario, and a sed directed messages designed to challer (iii) Analyze the ICI maintain documen exercises, and emit ICF/IID's emergenexercises, and emit ICF/IID's emergenexer annually. The totest the emergenest annually. The (i) Participate in a face community-based (A) When a consideration or. (B) If the HH/Or man-made emergency engaging in its near community-based functional exercise emergency event. (ii) Conduct an adopposite the year	itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based ; or r drill; or cise or workshop that is led by ludes a group discussion, linically-relevant emergency to f problem statements, s, or prepared questions age an emergency plan. F/IID's response to and tation of all drills, tabletop ergency events, and revise the cy plan, as needed. 4.102] HHA must conduct exercises acy plan at the HHA must do the following: full-scale exercise that is for formmunity-based exercise is not ct an annual individual, tional exercise every 2 years; A experiences an actual natural ergency that requires activation plan, the HHA is exempt from act required full-scale or individual, facility based the following the onset of the	E 039			

A CONTRACT OF THE CONTRACT OF THE	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING			0	4/15/2025
	PROVIDER OR SUPPLIER PRIVE GROUP HOME			628	REET ADDRESS, CITY, STATE, ZIP CODE B FLOWE DRIVE IARLOTTE, NC 28213		77 10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(A) (B)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	is conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disast (C) A tabletop exeled by a facilitator and discussion, using a nate mergency scenario, a statements, directed in questions designed to plan. (iii) Analyze the HHA's documentation of all discussion, using a nate mergency events, an emergency plan, as net a full table (ii) Analyze the emergency plan, as net a full table (ii) Conduct a paper-bat workshop at least annulled by a facilitator and it discussion, using a nate mergency scenario, a statements, directed mergency scenario, a statements, directed mergency plan. If the OPO experiman-made emergency the emergency plan, the engaging in its next region of the conset of the documentation of all tall tall tall tall tall tall tall	er may include, but is not scale exercise that is in individual, facility-based er drill; or ercise or workshop that is includes a group rrated, clinically-relevant and a set of problem nessages, or prepared challenge an emergency response to and maintain ills, tabletop exercises, and drevise the HHA's ededd. O] O must conduct exercises olan. The OPO must do the sed, tabletop exercise or ally. A tabletop exercise is includes a group rated, clinically relevant and a set of problem essages, or prepared challenge an emergency ences an actual natural or that requires activation of the OPO is exempt from uired testing exercise the emergency event. esponse to and maintain toletop exercises, and revise the [RNHCI's and	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	COMPLETED	
		34G227	B. WING		04/15/2025
	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE CHARLOTTE, NC 28213	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
E 039	exercises to test the must do the following (i) Conduct a paper least annually. A target discussion led by a clinically-relevant of problem statement of pro	a.748]: RNHCI must conduct the emergency plan. The RNHCI ing: Ir-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set tents, directed messages, or s designed to challenge an IHCI's response to and station of all tabletop exercises, vents, and revise the RNHCI's as needed. is not met as evidenced by: eview and interview, the facility siennial testing of the facility's iredness Plan (EPP). The Ility's EPP on 4/14/25 revealed a dated 3/6/25. Continued review ince of an additional full-scale ir-based exercise or mock drill qualified intellectual disabilities P) on 4/15/25 confirmed the inducted an additional full-scale ir-based exercise or mock drill DY a)(1) addy must exercise general policy, and revise general policy, and revise at a service of a service or mock drill and review and intellectual disabilities and review and intellectual disabilities by on 4/15/25 confirmed the and additional full-scale are review and intellectual disabilities by on 4/15/25 confirmed the and additional full-scale are review and interview and intellectual disabilities by on 4/15/25 confirmed the and additional full-scale are review and interview and intervie	E 039	The group home manager vinitiate a full-scale evacuation exercise to ensure staff and individuals are effectively educated on the process and for evacuation. The group hanager will make sure the required calls to authorities evacuate the home to the satisfie. Op will follow up to redocumentation and the team discuss the results of the evacuation exercise.	d plans nome and afety eview
	budget, and oper	ating direction over the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING		0.	4/15/2025
	PROVIDER OR SUPPLIER DRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		W13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROVIDER CORRECTION OF THE APPROPRIES (PROVIDER CORRECT))	DBE	(X5) COMPLETION DATE
	This STANDARD is a Based on observation governing body failed budget, and operating relative to hygiene sure observations through revealed hand soap to bathrooms. Continued the survey revealed of the bathroom without Further observations at to provide body wash washing before meals Interview with the qual professional (QIDP) of clients should have accompany to the facility must ensure the facility must ensure the facility must ensure the facility facility must ensure the facility facility facility in the facility facility in the facility facility facility in the facility f	not met as evidenced by: ns and interview, the d exercise general policy, g direction over the facility ipplies. The finding is: nout the 4/14-15/25 survey be unavailable in the client d observations throughout dients to independently use access to hand soap. at meal time revealed staff to support clients with hand s. lified intellectual disabilities in 4/15/25 confirmed all iccess to hand soap in the descriptions. The rights of all clients. The rights of all clients. The record review and field to ensure that privacy of 6 clients (#4). The finding other client in order to	W 130	Qp will do an in-service to educate staff of the importate hygiene supplies for the he and safety of our individual will remind staff of the unimportance of hand washin prevent sickness and the spacems. Group home managemonitor hygiene products in home to make sure the hygitems are available and easi accessible.	ance of alth ls. Qp versal g to read of er will n the iene	

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			528 FLOWE DRIVE			
(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
while the other clie and the door to the and the door to the Interview with the professional (QIDI should ensure clie personal care and PROGRAM IMPLE CFR(s): 483.440(d). As soon as the intervention of the each client must reatment program interventions and and frequency to so objectives identified plan. This STANDARD Based on observation interviews, the fact clients (#4) receive treatment program Person-Centered communication to mealtime guideling. During evening of on 4/14/25, client individual activities consisted of beef	ent remained in the restroom e restroom remained open. qualified intellectual disabilities P) on 4/15/25 confirmed all staff ents' privacy is protected during I treatment. EMENTATION d)(1) erdisciplinary team has t's individual program plan, eceive a continuous active in consisting of needed services in sufficient number support the achievement of the ed in the individual program is not met as evidenced by: ations, record review and cility failed to ensure that 1 of 6 and a continuous active in as identified in the Plan (PCP) relative to use of a sol and staff implementation of les. The finding is: beservations in the group home #4 was observed to take part in es and to eat dinner which ravioli, green beans, and sugar		Qp will re-educate staff in-service on the import our clients right to Priva group home manager wi staff to ensure privacy p being respected at all tire	ance of acy. The ill monitor policy is	6/5/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME SUMMARY (EACH DEFICIE REGULATORY) Continued From p while the other clie and the door to the Interview with the professional (QIDI should ensure clie personal care and PROGRAM IMPLE CFR(s): 483.440(As soon as the int formulated a clien each client must r treatment program interventions and and frequency to s objectives identified plan. This STANDARD Based on observatinterviews, the fact clients (#4) receives treatment program Person-Centered communication to mealtime guidelin During evening of on 4/14/25, client individual activities consisted of beef free pudding. Fur during the dinner #4 to put her fork	CORRECTION IDENTIFICATION NUMBER: 34G227 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 while the other client remained in the restroom and the door to the restroom remained open. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all staff should ensure clients' privacy is protected during personal care and treatment. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program	ROVIDER OR SUPPLIER RIVE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 while the other client remained in the restroom and the door to the restroom remained open. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all staff should ensure clients' privacy is protected during personal care and treatment. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that 1 of 6 clients (#4) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to use of a communication tool and staff implementation of mealtime guidelines. The finding is: During evening observations in the group home on 4/14/25, client #4 was observed to take part in individual activities and to eat dinner which consisted of beef ravioli, green beans, and sugar free pudding. Further observations revealed that during the dinner meal, no staff prompted client #4 to put her fork down after each bite of food	RIVE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 while the other client remained in the restroom and the door to the restroom remained open. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all staff should ensure clients' privacy is protected during personal care and treatment. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that 1 of 6 clients (#4) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to use of a communication tool and staff implementation of mealtime guidelines. The finding is: During evening observations in the group home on 4/14/25, client #4 was observed to take part in individual activities and to eat dinner which consisted of beet ravioli, green beans, and sugar free pudding. Further observations revealed that during the dinner meal, no staff prompted client #44 to put her fork down after each bite of food	A BUILDING 340227 A BUILDING 340227 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$28 FLOWE DRIVE SUMMARY STATEMENT OF DEPICIENCIES LECAN DEPICIENT WILST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 while the other client remained in the restroom and the door to the restroom remained open. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/25 confirmed all staff should ensure clients' privacy is protected during personal care and treatment. PROGRAM IMPLEMENTATION CFR(s): 483.440/(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan. This STANDARD is not met as evidenced by: Based on observations in the group home and frequency to support the achievement of the objectives identified in the healtewenent of the objectives identified in the Person-Centered Plan (PCP) relative to use of a communication tool and staff implementation of mealtime guidelines. The finding is: During evening observations in the group home on 4/14/25, client #4 was observed to take part in individual activities and to eat dinner which consisted of beef ravioli, green beans, and sugar free pudding. Further observations revealed that during the dinner meal, no staff prompted client #4 to put her fork down after each bite of food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE	(X3) DATE SURVEY COMPLETED		
		34G227	B. WING	04	04/15/2025	
	PROVIDER OR SUPPLIER PRIVE GROUP HOME		62	REET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE HARLOTTE, NC 28213		13/2023
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	table and take her dis Subsequent observations witch that was placed dinner table, but that switch, nor was she properties on 4/15/25, client #4 non-verbally to staff to Further observations to redirect client #4 to #4 refused. Continued to eventually allow coffee, but at no time to use a Big Mack swice Subsequent observations consume her meal ray meal was client #4 prodown after each bite to observation revealed table and take her discobservation revealed t	ork down. Continued of client #4 to get up from the shes to the kitchen. Into revealed a Big Mack and at client #4's place at the client #4 never used the prompted to use the switch of the living room, but client and observation revealed staff client #4 to prepare a cup of did staff C prompt client #4 to request her coffee. In the living room, but client are dobservation revealed staff client #4 to prepare a cup of did staff C prompt client #4 to fast meal which consisted of al, prune juice and milk. In the prompted to put her spoon of food. Additional client #4 to get up from the hes to the kitchen. Finally, as Big Mack switch that was lace at the breakfast table, or used the switch, nor was the switch by any staff.	W 249			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		34G227	B. WING		04	/15/2025
1590 ELSR (ALC SE 33 C E) 47 (A	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	"Put down her utensil no more than 2 verbal Interview with the quaprofessional (QIDP) of staff should have professional that should have professional that should have graded that all drugs, including self-administered, are that all drugs, including should have a demandated on observation interview, the facility of drugs, including those were administered with the should have a demandated with the should have a demandated on the should hav	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 administration must assure ing those that are administered without error, not met as evidenced by: in, record review and failed to ensure that all ite that are self-administered, thout error for 1 of 6 clients bup home on 4/15/25 at 6:30 at the inued observation at 7:45 at the inued observation at 7:45 at the inued observation pass selve the following two is sulfate - 15 mL dose on cup by Staff B and taken rosint Solution - ith staff assistance and 5 minutes after the record on 4/15/25 revealed ted 3/19/25. Review of the	W 369	goals as written. Group hon manager will monitor staff to ensure goals are being run a written and that all adaptive equipment is used properly.	the ne to ss	6/5/2025

PRINTED: 04/17/2025 FORM APPROVED

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G227	B. WING	NG04/15/20		
	PROVIDER OR SUPPLIER PRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	1 04	13/2023
(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)	BE .	(X5) COMPLETION DATE
	Iron (75mg)/mL Oral I by oral route; Tirosint-Solution - Take 1 mL morning at least 30 m Interview with Staff B administered a 15 mL client #2. Interview with 4/15/25 confirmed clie orders are current. Conclient #2 received the Sulfate. Further intervishould have received minutes before breakfaminutes befor	e: Ferrous Sulfate 15 mg Drops - Take 1 mL every day SoL 62.5 mcg/mL Oral by mouth daily in the inutes before breakfast. on 4/15/25 verified they dose of Ferrous Sulfate to h the facility nurse on nt #2's AM medication ntinued interview confirmed incorrect dose of Ferrous ew confirmed client #2 the Tirosint Solution 30 ast as prescribed. ii) n appropriate quantity. of met as evidenced by: 6, record reviews and ailed to ensure food was atte quantity for 4 of 6 #5). The findings are: bup home on 4/14/25 all revealed all clients to be en beans and sugar free vation revealed the meal e, with no measuring tools ith portioning food on their es indicated on the daily oil, ½ cup of green beans, Subsequent observation	W 472	Lifespan Nurse will re-educe the staff with an in-service of medication administration per Group home manager will me staff to ensure the policy is befollowed daily.	n the olicy. onitor	6/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONST A. BUILDING 34G227 B. WING		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 DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 472	during breakfast re Cream of Wheat co observation reveals family style with clis serve themselves to Subsequent observation reveals made by staff to me themselves and the larger or smaller the individually prescrit Review of client #1 a nutritional evaluat indicates client #1 meats, double port Review of client #2 meats, double port Review of client #3 a nutritional evaluat indicates client #3 heart healthy, ½ po double portions of Review of client #8 a nutritional evaluat indicates client #3 heart healthy, ½ po double portions of Review of client #8 a nutritional evaluat indicates client #5 healthy, chopped a all meals. Interview with the professional (QIDI clients' prescribed interview with the	e group home on 4/15/25 vealed all clients to be served ereal and prune juice. Further ed the meal to again be served ents using a large spoon to the Cream of Wheat cereal. vations revealed no effort easure the food clients served e servings appeared to be an called for by clients' bed diets. 's record on 4/15/25 revealed ation dated 2/11/25 which is prescribed diet to be chopped ations at all meals, no milk. E's record on 4/15/25 revealed ation dated 2/11/25 which is prescribed diet to be chopped ations at all meals. E's record on 4/15/25 revealed ation dated 2/11/25 which is prescribed diet to be chopped ations at all meals. E's record on 4/15/25 revealed ation dated 2/11/25 which is prescribed diet to be regular, ortions of starch and desserts,	W 472			

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	3		11512025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		04/15/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 472	Continued From page prescribed.	22		Dietician will do an in- the importance of follow dietary orders for all cli will be re-educated on t used to measure quantit adaptive equipment nee mealtimes for some of c individuals. Qp will foll observe mealtimes to en orders are being follower	wing ents. Staff the items by and the eded at our low up to assure diet	6/5/2025	