PRINTED: 06/24/2025 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G227	B. WING_	B. WING		R 06/23/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 628 FLOWE DRIVE CHARLOTTE, NC 28213	CODE	06/23/2025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
{E 015}	(1), §460.84(b)(1), §485. [(b) Policies and procedure policies and procedure policies and procedure plan set forth in paragrand the communication this section. The policies reviewed and update for LTC facilities]. At a procedures must addition the policies and patients whether place, include, but are (i) Food, water, medical supplies (ii) Alternate sources following: (A) Temperatures to pasafety and for the safety and for the	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 int emergency preparedness es, based on the emergency raph (a) of this section, risk aph (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 a not limited to the following: all and pharmaceutical of energy to maintain the rotect patient health and a and sanitary storage of g. inguishing, and alarm e disposal. e at §418.113(b)(6)(iii):] es. additional requirements for atient care facilities only, edures must address the	{E 0	15}			

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

TITLE (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		34G227	B. WING_			06/	23/2025
	ROVIDER OR SUPPLIER			62	TREET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE HARLOTTE, NC 28213		
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{E 015}	evacuate or shelter in limited to the following (A) Food, water, medisupplies. (B) Alternate sources following: (1) Temperatures to pafety and for the safe provisions. (2) Emergency lightin (3) Fire detection, extractions, extractions, extractions. (C) Sewage and wast This STANDARD is ranged that the emergency and the experience of compliance as to the EP Testing Requiremed CFR(s): 483.475(d)(2) \$416.54(d)(2), \$483.475(d)(2), \$483.475(d)(2), \$484.5.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.727, CMHCs at \$485.727, CMHCs at \$491.12, and ESRD for the emergency must do all of the following surveys the emergency must do all of the following surveys the same surveys to survey the same surveys to survey the same surveys the same surveys the same surveys to survey the same surveys to survey the same surveys to surveys the same surveys the same surveys to surveys the same surveys the same surveys the same surveys to surveys the same surveys to	and patients, whether they place, include, but are not g: ical, and pharmaceutical of energy to maintain the protect patient health and e and sanitary storage of g. inguishing, and alarm see disposal. In the facility remains out nis deficiency. In the facility remains out nis deficienc	{E 0				
	(i) Participate in a full-	-scale exercise that is					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G227	B. WING			R 06/23/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 628 FLOWE DRIVE CHARLOTTE, NC 28213	•	00/23/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
{E 039}	accessible, conduct exercise every 2 year (B) If the [facility natural or man-made activation of the eme exempt from engagic community-based or functional exercise from actual event. (ii) Conduct an addity years, opposite the functional exercise to this section is conducted in the section of the functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercises; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercises, and a set of directed messages, designed to challent (iii) Analyze the [facility's] emergence *[For Hospices at 41 (2) Testing for hospicationally. The hospicational reversions to test the annually. The hospices are reconstructed to the second reversions to test the annually. The hospices are reconstructed to the second reversions to test the annually. The hospices are reconstructed reversions to test the annually. The hospices are reconstructed reversions to test the annually. The hospices are reconstructed reversions to test the annually. The hospices are reconstructed reversions to test the annually. The hospices are reversions to test the annually.	very 2 years; or nity-based exercise is not a facility-based functional ars; or y] experiences an actual e emergency that requires ergency plan, the [facility] is ng in its next required individual, facility-based ollowing the onset of the ional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of icted, that may include, but is owing: ale exercise that is individual, facility-based or drill; or ise or workshop that is led by udes 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 y plan, as needed. 8.113(d):] ices that provide care in the e hospice must conduct emergency plan at least ce must do the following: ull-scale exercise that is	{E 0	39}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		34G227	B. WING		R 06/23/2025		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	1 00/20/202	<u> </u>	
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{E 039}	accessible, conduct a functional exercise e (B) If the hospice examan-made emergency the emergency plan, engaging in its next and community-based examan-made emerger (ii) Conduct an addition onset of the exercise under paragis conducted, that material to the following: (A) A second full-scatcommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator and inclusing a facilitator and inclusing a facilitator and a set of the exercises to the exercises to test the year. The hospice of (i) Participate in an assistant of the proposed function (ii) Participate in an assistant of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emergence of the proposed function (iii) If the hospice examan-made emer	ity based exercise is not an individual facility based very 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale ercise or individual nal exercise following the ncy event. ional exercise every 2 years, a full-scale or functional graph (d)(2)(i) of this section and include, but is not limited alle exercise that is a facility based functional drill; or isse or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions e an emergency plan. The state provide inpatient respice must conduct emergency plan twice per nust do the following: annual full-scale exercise is not an annual individual	{E 03	9}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE CHARLOTTE, NC 28213	1 001	23/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{E 039}	based or facility-base following the onset of (ii) Conduct an additional may include, but is not (A) A second full-scal community-based or exercise; or (B) A mock disaster of (C) A tabletop exercifacilitator that include narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentative exercises, and emerge hospice's emergency *[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 ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hospital accessible, conduct and a community of [facility] is exempt fro required full-scale contents.	equired full-scale community d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to not plan. sice's response to and ion of all drills, tabletop gency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not an annual individual,	{E 0	039}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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{E 039}	and that may include following: (A) A second full-sca community-based or functional exercise; o (B) A mock of (C) A tabletop exeled by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the [maintain documentate exercises, and emerge [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the exannually. The PACE of following: (i) Participate in an assistant community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experimental emergency plan, engaging in its next rebased or individual, faexercise following the event.	cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based r disaster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop lency events and revise the plan, as needed. (4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not an annual individual,	{E 0	039}				

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		R 06/23/2025	
	ROVIDER OR SUPPLIER RIVE GROUP HOME			6	STREET ADDRESS, CITY, STATE, ZIP CODE 128 FLOWE DRIVE CHARLOTTE, NC 28213	1 0011	20/2020
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{E 039}	exercise under paragis conducted that may the following: (A) A second full-sca community-based or functional exercise; o (B) A mock disaster of the functional exercise; o (B) A mock disaster of the functional exercise; o (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC maintain documentatic exercises, and emerge PACE's emergency procedures (2) The [LTC facility] of the function (B) If the [LTC facility] actual natural or man requires activation of LTC facility is exempting the function of the function	ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based redrill; or see or workshop that is led by des a group discussion, cally-relevant emergency for problem statements, reprepared questions ean emergency plan. E's response to and on of all drills, tabletop tency events and revise the lan, as needed. E\(\frac{4}{3}\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \(3\) \(4\) \(3\) \({E 0	039}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213	-	00/23/2023		
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{E 039}	may include, but is r (A) A second full-so community-based or functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator includes narrated, clinically-reand a set of problem messages, or preparchallenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emer [LTC facility] facility's *[For ICF/IIDs at §48 (2) Testing. The ICF to test the emergency The ICF/IID must do (i) Participate in an ais community-based (A) When a community-based (A) When a community-based function (B) If the ICF/IID expman-made emergency plantengaging in its next community-based or functional exercise femergency event. (ii) Conduct an addit may include, but is r (A) A second full-soa	and limited to the following: ale exercise that is an individual, facility based or drill; or sise or workshop that is led by a group discussion, using a elevant emergency scenario, a statements, directed red questions designed to ency plan. C facility] facility's response to entation of all drills, tabletop gency events, and revise the semergency plan, as needed. 33.475(d)]: //IID must conduct exercises by plan at least twice per year. the following: annual full-scale exercise that c or inty-based exercise is not an annual individual, anal exercise; or. beriences an actual natural or cy that requires activation of the ICF/IID is exempt from required full-scale individual, facility-based collowing the onset of the ional annual exercise that iot limited to the following: ale exercise that is an individual, facility-based or	{E 03	39}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G227	B. WING			⋜ 23/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213			23/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRIDE DEFICIENCY)			(X5) COMPLETION DATE
{E 039}	a facilitator and include using a narrated, clin scenario, and a set or directed messages, or designed to challenge (iii) Analyze the ICF/I maintain documentate exercises, and emergic ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The HI (i) Participate in a full community-based; or (A) When a community-based function or. (B) If the HHA e or man-made emergency event. (ii) Conduct an addition opposite the year the exercise under paragis conducted, that limited to the following (A) A second full community-based or functional exercise; or (B) A mock disast	des a group discussion, deally-relevant emergency of problem statements, or prepared questions an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. O2] HA must conduct exercises or plan at HA must do the following: -scale exercise that is 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 llowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section that may include, but is not general exercise that is an individual, facility-based treation of the contained of t	{E 0	39}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER FLOWE DRIVE GR		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD 628 FLOWE DRIVE CHARLOTTE, NC 28213		00/23/2025	
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led by discus emerg statem questing plan. (iii) An docum emerg emerg emerg *[For (d)(2)) to test followi (i) Corworksl led by discus emerg statem questing plan. I mann the emengag followi (ii) An docum emerg OPO's *[RNC (d)(2) exercis must co (i) Cor	sion, using a nency scenario, nents, directed ons designed to alyze the HHA nentation of all ency events, a ency plan, as recording. The Othe emergency not at least and a facilitator and a facilitator and sion, using a nency scenario, nents, directed ons designed to find the OPO expended emergency plan, ing in its next reng the onset of alyze the OPO entation of all ency events, and emergency plan, ing the onset of alyze the OPO entation of all ency events, and emergency plan, ing the onset of alyze the OPO entation of all ency events, and emergency plan, ing the onset of alyze the OPO entation of all ency events, and emergency plan, ing the onset of alyze the OPO entation of all ency events, and emergency plan, inguitable to the following and the following	d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency 's response to and maintain drills, tabletop exercises, and nd revise the HHA's needed. 360] PO must conduct exercises or plan. The OPO must do the massed, tabletop exercise or nually. A tabletop exercise is d includes a group arrated, clinically relevant and a set of problem messages, or prepared or challenge an emergency eriences an actual natural or extra trequires activation of the OPO is exempt from equired testing exercise if the emergency event. s response to and maintain tabletop exercises, and and revise the [RNHCI's and lan, as needed. 48]: NHCI must conduct emergency plan. The RNHCI	{E 0:	39}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	340221	B. WING	S 6	TREET ADDRESS, CITY, STATE, ZIP CODE 28 FLOWE DRIVE CHARLOTTE, NC 28213	06/	23/2025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{E 039}	clinically-relevant emotor problem statement prepared questions demergency plan. (ii) Analyze the RNHO maintain documentati and emergency even emergency plan, as no This STANDARD is no evidence was provideficiency has been of	acilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and ion of all tabletop exercises, ts, and revise the RNHCI's needed. not met as evidenced by: urvey conducted on 6/23/25, vided to verify that this	{E 0	939}				