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
	34G328	A. BUILDING _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

(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) COMPLETION DATE
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020	RECEIVED 2 7 2026 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Co-Residential Director 2/25/26

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	(X3) DATE SURVEY COMPLETED
	34G328	A. BUILDING _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

(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) COMPLETION DATE
E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuating locations based on a community and facility based risk assessment. This had the potential to affect all clients (#1, #2, #3, #4 and #5). The findings is: Review on 2/10/26 of the facility's EP dated 4/30/24 revealed the plan did not include any information in regard to the facility's evacuation locations in the event of flood, fire, tornado, hurricane, storms, bioterrorism and other emergencies. Interview on 2/10/26 with the residential manager (RM) revealed that she was unaware that it was a requirement.	E 020	ASMC will show evidence that the Emergency Preparedness Plan (EP) and Risk Assessment is updated and reflects information that clearly identifies the facility's evacuation maps/locations in the event of flood, fire, tornado, hurricane, storms, bio-terrorism and other emergency. All staff will be in-serviced on the updated evacuation locations and procedures. The Risk Assessment will be reviewed annually by ASMC'S administrative team.	4/10/26
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i)	W 340		

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
	34G328	A. BUILDING _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

(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) COMPLETION DATE
W 440	Continued From page 3 at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: Review of the facility's fire drill reports from 1/25-1/26 on 2/9/26 revealed no 1st shift fire drill for the 1st, 2nd, and 3rd quarters of 2025. Continued review revealed no 1st and 3rd shift fire drill for the 4th quarter of 2025. Interview with the Residential Director on 2/10/26 revealed they have no further evidence of fire drill records. Continued interview confirmed fire drills should be conducted quarterly for each shift of personnel.	W 440	ASMC will show evidence that the facility conducts an immediate review of the drill records for the last 12 months and will schedule and complete any missed evacuation drills on each shift to ensure drills were conducted on all shifts. Additionally, all staff will undergo in-service training on fire and disaster drills procedure. The program Coordinator will observe and document accuracy of fire/disaster during 1st, 2nd, 3rd shifts over the next quarter and the QIDP will review monthly reports to ensure completion.	4/10/26
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that 1 of 3 audit clients (#3) was provided with appropriate utensils to allow each client to eat as independently as possible according to their highest functioning level. The finding is: Afternoon observations on 2/9/26 at 5:42 PM revealed clients to sit at the dining room table to prepare for the dinner meal. The dinner meal consisted of the following: tomato curry lentil stew, brown rice, roasted vegetables, and water. Further observations revealed client #3 to participate in the dinner meal without his angled	W 475	The facility will show evidence that client # 3 has appropriate adaptive utensils needed to promote safe and independent dining. All Direct Support Professionals will undergo in-service training on the appropriate adaptive utensils needed for client # 3. Additionally, the Program Manager/ Qualified Professional will conduct 2 X weekly meal observation for 2 weeks to ensure proper usage of adaptive utensils..	4/10/26

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
	34G328	A. BUILDING _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

(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) COMPLETION DATE
W 340	Continued From page 2 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure staff were sufficiently trained to properly utilize latex gloves. The finding is: During morning observations on 2/10/26 from 6:55 AM -7:16 AM revealed Staff A to put on a pair of latex gloves and began touching various surfaces and items in the kitchen. Continued observations revealed Staff A to remove the footrest from client # 1's wheelchair, place shirt protectors on two clients, place clients' silverware and plates on the dining table all while wearing the same gloves. Further observations revealed Staff A dropped a bowl on the floor, took it to the sink and washed it while wearing the same gloves. During an additional morning observation revealed Staff A to serve client #2 pancakes and sliced each one into small pieces with a knife while wearing the same gloves. Further observations revealed Staff A to get a hole in one glove after cutting the pancakes and he removed only that one glove and replaced it with a new glove. Interview on 2/10/26 with the facility nurse revealed staff should be following the facility's policy regarding glove use.	W 340	ASMC will show evidence that all staff are immediately re-trained by the Director Of Nursing on the proper utilization of latex gloves. The Program Coordinator/QIDP will observe and document staff's proper utilization of gloves during breakfast, lunch and dinner 2 X weekly for 2 weeks.	4/10/26
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 440		

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
	34G328	A. BUILDING _____ B. WING _____	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAIL B HANKS GROUP HOME	5917 ROWAN WAY CHARLOTTE, NC 28214

(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) COMPLETION DATE
W 475	Continued From page 4 adaptive spork. At no point during the observation did staff provide the adaptive equipment needed during the dinner meal as prescribed. Morning observations on 2/10/26 at 6:55 AM revealed clients to participate in the breakfast meal. The breakfast meal consisted of the following: turkey bacon, oatmeal, coffee, and juice. Further observations revealed client #3 to participate in the breakfast meal without his angled adaptive spork. At no point during the observation did staff provide the adaptive equipment needed during the breakfast meal as prescribed. Review of the record for client #3 revealed physician orders dated 12/21/25 which indicated the client has the following adaptive equipment during mealtimes: high sided divided dish or scoop bowl, and an angled adaptive spork. Interview with the Residential Director on 2/10/26 verified that client #3 have adaptive equipment that must be used during mealtimes and that the physician orders are current.	W 475		