STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G105	A. BUILDING _____ B. WING _____	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
23RD STREET HOME	804 EAST 23RD STREET NEWTON, NC 28658

(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 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: The facility failed to consistently provide prescribed adaptive eating utensils during meals for 1 of 3 sampled clients (#5) as evidenced by observations, interviews and record reviews. The finding is: Observations in the group home on 5/29/18 of the evening meal revealed client #5's adaptive equipment to include a high sided divided plate, a coated spoon with a small bowl, regular size fork, dycum mat and an elevated tray. Continued observation in the group home during the morning meal on 5/30/18 revealed the adaptive equipment for client #5 to include a dycum mat, a small bowled spoon and a small fork, scoop bowl and elevated tray. Subsequent observations revealed the client did not exhibit significant spillage during either meal. Review of the records for client #5, verified by interview with the qualified intellectual disabilities professional, revealed a person centered plan (PCP) dated 1/29/18 describing client #5's adaptive equipment to include high sided divided plate, dycum mat and raised platform. Continued review of client #5's records revealed a 6/26/17 occupational therapy (OT) assessment which stated the client needs an "elevated tray, high sided divided plate, small bowled spoon and non-skid mat." Continued review of the OT	W 484		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G105	A. BUILDING _____ B. WING _____	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
23RD STREET HOME	**804 EAST 23RD STREET NEWTON, NC 28658**

(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 484	Continued From page 1 assessment revealed the small bowled spoon should be larger than a coated baby spoon such as a small maroon spoon. Therefore, the facility is not consistently providing the client #5 with appropriate adaptive equipment to meet identified needs in dining.	W 484		