STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE** **WINSTON-SALEM, NC 27107**

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure privacy during care of personal needs for 1 of 6 sampled clients (#2). The finding is: Observations in the group home on 2/26/2020 at 6:45 AM revealed client #2 asleep in his room with the door open. Further observations at 7:30 AM revealed client #2 in the bathroom closest to his room, completing his personal hygiene routine with the door slightly open. Further observations at 7:40 AM revealed staff F assisting client #2 in the same bathroom. Staff F then exited the bathroom leaving the door slightly open when another client attempted to enter. Staff E redirected the other client to wait until client #2 exited. Continued observations at 7:43 AM revealed client #2 to exit the bathroom and walk towards the laundry room and bedroom areas with his bathrobe open. Staff E immediately redirected client #2 to close his robe as he walked towards staff E. Client #2 was then observed entering his room to get dressed with the door open. Client #2 was not observed to be prompted by staff to close the door to ensure privacy. Review of medical record on 2/26/2020 revealed a person centered plan (PCP) dated 7/31/2019 indicating client #2 likes private time in his	W 130		

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	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 130	Continued From page 1 bedroom. Client #2's active treatment goals listed are but not limited to: bathing, operate washing machine, identify community safety, operate clothes dryer, state equivalency of coins, and behavior support. Interview with the qualified intellectual disabilities professional (QIDP) on 2/26/2020 confirmed that facility staff should assure no more than one client should be in a bathroom at one time in order to ensure client privacy during the care of personal needs. QIDP further confirmed staff should have prompted client #2 to close the door or staff should have closed the door to ensure privacy during care of personal needs.	W 130		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure the person centered plan (PCP) included training to address client needs relative to wheelchair use for 1 of 6 sampled clients (#12). The finding is: Observations on 2/25/20 at the day program revealed client #12 to be sitting in a wheelchair with a gait belt wrapped around the back of the seat and fastened over her lap. Continued observations throughout the survey from 2/25/20 to 2/26/20, client #12 was observed in the	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 227	Continued From page 2 wheelchair at all times except for transferring to a chair during lunch and transferring to a seat in the van for transport. During that time, staff H and staff I were pushing client #12 around from room to room at the day program as well as at the group home. Client #12 did not attempt to propel herself while in the wheelchair or stand up and ambulate with staff assistance. Record review on 2/26/20 of client #12's PCP dated 7/24/19 instructed that client #12 should use the wheelchair for long distances. Further review included the following recommendations: maintain daily walking opportunities plus 1 assist to maintain client #12's strength, dynamic balance and decrease edema. Continued review revealed a physical therapy (PT) consult dated 6/21/19, indicating use of a wheelchair for long distances and community outings. Interview at the group home on 2/25/19 with staff J revealed she did not know of any guidelines or programs for client #12's wheelchair. Further interview with staff L revealed she was not sure when client #12 should use the wheelchair. Interview on 2/26/20 with the qualified intellectual disabilities (QIDP) verified the PT consult and PCP directions to use the wheelchair for long distances and community outings were current, revealing there is not a program or guidelines for staff to follow for client #12's wheelchair use.	W 227		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ____ B. WING ____	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 371	Continued From page 3	W 371		

is an appropriate objective, and if the physician does not specify otherwise.

This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the system for drug administration failed to assure 2 of 2 clients (#1 and #6) observed during the medication pass were provided teaching related to name, purpose and side effects of medications administered. The findings are:

A. The system for drug administration failed to assure client #1 was provided teaching related to the name, purpose or possible side effects of medications received. For example:

Observations conducted on 2/26/2020 at 7:05 AM during medication administration revealed client #1 to receive medications including Acidophilus Probiotic Blend 1 cap and Bethameth Val Lot 0.1%. Continued observations revealed staff to pour a mixture of grape juice and water into a sippy cup. Further observation revealed staff D to prompt and provide hand over hand assistance with client #1 to punch medications into a medication cup. Client #1 was observed to take all medications mixed with applesauce with hand over hand assistance from staff. Client #1 was not observed to be provided with teaching related to the name, purpose or possible side effects of medications administered.

Review of medical record on 2/26/2020 revealed a person centered plan (PCP) dated 3/27/2019. Further review of the PCP revealed a medication administration strength section to include client #1 can punch out medications, pour his water,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE** **WINSTON-SALEM, NC 27107**

(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 371	Continued From page 4	W 371		

and dispose of trash when finished. Continued review revealed client #1 understands the purpose of his medications and can name and identify his medications on occasions if he chooses to.

Interview with the facility nurse on 2/26/2020 verified client #1 should have been provided education during his medication pass with identification of medication, purpose and side effects.

B. The system for drug administration failed to assure client #6 was provided teaching related to the name, purpose or possible side effects of medications received. For example:

Observations conducted on 2/26/2020 at 7:10 AM during medication administration revealed client #6 to receive medications including Amitiza cap 24 mcg, Carbamazepine 200mg, Cetirizine 10mg, Clonidine 0.1mg, Multivitamin tab, Vitamin C CHW 250mg, Chlorhexidine Gluc 0.12%, Benzoyl Peroxide Topical 10%. Continued observations during this medication administration revealed staff D to pour a mixture of grape juice and water in a cup. Further observation revealed staff D to prompt client #6 to punch medications into a medication cup. Client #6 was observed to take all medications mixed with applesauce spoon fed by staff. Client #6 was not observed to be provided with teaching related to the name, purpose or possible side effects of medications administered.

Review of medical record on 2/26/2020 revealed a person centered plan (PCP) dated 2/19/2020. Further review of the PCP revealed a medication administration strength section to include client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 371	Continued From page 5 #6 can punch out medications, pour his water, and dispose of trash when finished. Continued review revealed client #6 understands the purpose of his medications and can name and identify his medications. Interview with the facility nurse on 2/26/2020 verified client #6 should have been provided education during his medication pass with identification of medication, purpose and side effects.	W 371		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure a specifically prescribed diet was followed for 3 sampled clients (#2, #5, #6). The findings are: A. Client #2's specifically prescribed diet was not followed. Observation in the group home on the morning of 2/26/2020 at 8:45 AM revealed client #2 to sit at the dining table to independently pour juice and water into his cups. Continued observation revealed staff D to cut client #2's boiled eggs with rocker knife and staff F to offer whole bagels with cream cheese to client. Further observations revealed client #2 to participate in the breakfast meal consisting of cut boiled eggs, whole bagel with cream cheese, juice and water.	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 460	Continued From page 6 Review of records for client #2 on 2/26/2020 revealed a person centered plan (PCP) dated 7/31/2019. Review of the PCP revealed client #4 to have a regular 1/4 inch consistency diet, and double portions at meal times. No hot dogs, no mustard/collard greens, nothing in casing, and no spicy foods were listed as well. Further review of records for client #2 revealed a current physician's order for the client to have a regular diet with 1/4 consistency. Interview with the qualified intellectual disabilities professional (QIDP) on 2/26/2020 confirmed client #2 has a regular 1/4 consistency diet. The QIDP further confirmed client #2's prescribed diet should be followed at all meals and his bagel should have been cut into 1/4 pieces. B. Client #5's specifically prescribed diet was not followed. Observation in the group home on the morning of 2/26/2020 at 8:45 AM revealed client #5 to sit at the dining table to independently pour juice and water into his cups. Continued observation revealed client #5 to cut boiled eggs with a rocker knife. Further observations revealed client #5 to participate in the breakfast meal consisting of cut boiled eggs, whole bagel with cream cheese, juice and water. Review of records for client #5 on 2/26/2020 revealed a PCP dated 4/24/2019. Review of the PCP revealed client #5 to have a regular 1/2 inch consistency diet, with no seconds. Further review of records for client #5 revealed a current physician's order for the client to have a regular diet with 1/4 consistency. Continued review of	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 460	Continued From page 7	W 460		

record revealed a choking risk assessment dated 8/28/2019 which indicated the client eats at a rapid pace and diet modifications made to 1/2 consistency.

Interview with the QIDP on 2/26/2020 confirmed client #5 has a regular 1/2 consistency diet. The QIDP further confirmed client #5's choking risk assessment is current and the client's bagel should have been cut based on prescribed diet.

C. Client #6's specifically prescribed diet was not followed.

Observation in the group home on the morning of 2/26/2020 at 8:45 AM revealed client #6 to sit at the dining table and hand over hand assistance to fix the client's place and pour juice into his cup. Continued observation revealed staff D to then cut the client's boiled eggs with a rocker knife. Further observations revealed staff F to bring a cup of coffee to the client at the table and offer a whole bagel with cream cheese. Subsequent observations revealed the client to participate in the breakfast meal consisting of boiled eggs, whole bagel with cream cheese, juice and water.

Review of records for client #6 on 2/26/2020 revealed a PCP dated 2/12/2020. Review of the PCP revealed client to have a weight gain, 1/4 inch consistency diet, and ensure 4 oz. daily at 4pm. Further review of records for client #6 revealed a current physician's order for the client to have a weight gain, 1/4 inch consistency diet. Continued review of record revealed a choking risk assessment dated 2/12/2020. Review of the choking risk assessment revealed the client has poor control of food/liquid in mouth, difficulty swallowing medications, talks with food in mouth,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 460	Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. Interview with the QIDP on 2/26/2020 confirmed client #6 to have a weight gain, 1/4 inch consistency diet. The QIDP further confirmed client #6's choking risk assessment is current and client's bagels should have been cut based on his prescribed diet.	W 460		
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 observation and interview, the facility failed to assure 3 of 6 sampled clients (#2, #5, #6) and 1 non sampled client (#3) were provided with appropriate utensils to enable them to eat as independently as possible in accordance with their highest functioning level. The findings are: A. The facility failed to assure client #2 was provided with appropriate utensils during the dinner meal. Dinner observations on 2/25/2020 in the group home at 5:45 PM revealed client #2 consuming his meal consisting of salmon stir fry, rice, vegetables, and apple cinnamon bread. Further observations revealed client #2 had a regular spoon and rocker knife which was shared with another client during this meal. At no time did staff offer or provide client #2 with a fork. Interview on 2/26/2020 with the qualified intellectual disabilities professional (QIDP)	W 475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 9	W 475		

Continued From page 9

confirmed client #2 requires a rocker knife to eat his meals. Further interview confirmed client #2 can appropriately use all utensils. Continued interview confirmed client #2 should be provided with a place setting consisting of a rocker knife, fork and spoon during all meals.

B. The facility failed to assure client #5 was provided with appropriate utensils during the dinner meal.

Dinner observations on 2/25/2020 in the group home at 5:30 PM revealed client #5 consuming his meal consisting of salmon stir fry, rice, vegetables and apple cinnamon bread. Further observations revealed client #5 had a regular spoon during this meal and shared a rocker knife with another client. At no time did staff offer or provide client #5 with a fork.

Interview on 2/26/2020 with the QIDP confirmed client #5 can appropriately use all utensils. Further interview with QIDP confirmed client #5 should be provided with a place setting consisting of a rocker knife, fork and spoon during all meals.

C. The facility failed to assure client #6 was provided with appropriate utensils during the dinner meal.

Dinner observations on 2/25/2020 in the group home at 5:30 PM revealed client #6 consuming his meal consisting of salmon stir fry, rice, vegetables, and apple cinnamon bread. Further observations revealed client #6 had a regular spoon during this meal. At no time did staff offer or provide client #6 with a fork and knife.

Interview on 2/26/2020 with the QIDP confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 10	W 475		

client #6 can appropriately use all utensils. Further interview with QIDP confirmed client #6 should be provided with a place setting consisting of a knife, fork and spoon during all meals.

D. The facility failed to assure client #3 was provided with appropriate utensils during the dinner meal.

Dinner observations on 2/25/2020 in the group home at 5:30 PM revealed client #3 consuming his meal consisting of salmon stir fry, rice, vegetables and apple cinnamon bread. Further observations revealed client #3 had a regular spoon during this meal. At no time did staff offer or provide client #3 with a fork and knife.

Interview on 2/26/2020 with the QIDP confirmed client #3 can appropriately use all utensils. Further interview with QIDP confirmed client #3 should be provided with a place setting consisting of a knife, fork and spoon during all meals.