STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessment (CFA) included an assessment of each client's independent living skills and abilities. This affected 2 of 4 audit clients. (#1 and #6) The finding is: A. Review on 6/22/21 of client #1's Community/Home Life Assessment (CHLA) form dated 1/13/21 included self-care, grooming, dressing, toileting, domestic tasks, dining, meal preparation, money management, and other skill areas. Client #1's CHLA was completely blank after the first page. Interview on 6/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's CHLA had not been filled out completely. B. Review on 6/22/21 of client #6's record revealed a CHLA had not been completed including an assessment of his self-care, grooming, dressing, toileting, domestic tasks, dining, meal preparation, money management, and other skill areas. Interview on 6/22/21 with the QIDP confirmed the CHLA had not been completed for client #6.	W 224		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 249	Continued From page 1	W 249		

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 each client receives a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of cooking skills. This affected 1 of 4 audit clients. The finding is:

During 3 of 3 food preparation observations in the home throughout the survey on 6/21 - 6/22/21, staff completed the majority of cooking tasks without any client involvement. With the exception of client #1 placing meat and cheese on a single slice of bread on 6/21/21 and another client operating a toaster on one occasion on 6/23/21, no clients were prompted or encouraged to participate with cooking tasks.

Interview on 6/22/21 with Staff B revealed clients can assist with cooking by operating the toaster or stirring things. Additional interview indicated clients can help set up for the meal.

Review on 6/22/21 of client #1's IPP dated 1/13/21 revealed, "[Client #1] does require some supervision and assistance with his activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 249	Continued From page 2 daily living...possesses some basic self-help skills." Interview on 6/22/21 with the Site Supervisor confirmed all of the clients in the home "are capable" of assisting with cooking tasks and should be encouraged to complete these tasks in the kitchen.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure data relative to client #4's Physical Therapy (PT) exercises was documented as indicated. This affected 1 of 4 audit clients. The finding is: A. Review on 6/22/21 of client #4's data collection book revealed documentation of PT exercises. The documentation noted the following days of implementation: 01/21 - 16 days 02/21 - 11 days 03/21 - 10 days 04/21 - No documentation 05/21 - No documentation 06/21 - 10 days as of 6/22/21 Review on 6/22/21 of client #4's record revealed	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 252	Continued From page 3 guidelines for a PT exercise program (dated 4/2/20). Additional review of PT exercises noted, "Passive range of motion exercises for both lower extremities...Staff should perform these exercises with [Client #4]. Staff should perform five repetitions of each exercise...Staff should encourage [Client #4] to participate daily in exercise program for him to achieve optimum benefit from exercises." Further review of the program noted, "Staff should document [Client #4's] participation on the monthly exercise program log." Interview on 6/22/21 with the Site Supervisor indicated staff should be documenting client #4's PT exercises; however, she had only recently began working in the home and could not be sure about any documentation prior to her arrival.	W 252		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 4 audit clients (#4 and #5). The findings are: A. Review on 6/22/21 of client #4's Behavior Support Plan (BSP) dated 11/20/19 revealed objectives to exhibit 1 or fewer episodes of non-compliance, self-injurious behavior and	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 263	Continued From page 4 inappropriate verbalizations per month for 12 consecutive months. The BSP incorporated the use of Clonazepam, Clonidine and Trazodone. Additional review of the record revealed no written informed consent for the BSP. Interview on 6/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no current consent was available for review. B. Review on 6/22/21 of client #5's Behavior Support Plan (BSP) dated 3/24/21 revealed an objective to exhibit 1 or fewer episodes of agitation per month for 12 consecutive months. The BSP incorporated the use of Risperdal. Additional review of the record revealed no written informed consent for the BSP. Interview on 6/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no current consent was available for review.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure drugs used to manage client #6's inappropriate behaviors were used only as an integral part of his Individual Program Plan. This affected 1 of 4 audit clients. The finding is:	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 312	Continued From page 5 Review on 6/22/21 of client #6's physician's orders signed 4/1/21 revealed orders for Abilify 5mg, take 1 tablet by mouth every morning, Zyprexa 20mg, take 1 tablet by mouth every evening, Trazodone 150mg, take 1 capsule by mouth every evening, Clonidine .1mg, take 1 tablet by mouth twice daily and Melatonin 5mg, take 1 tablet by mouth every evening. Additional review of the record indicated the medications were prescribed for sleeplessness, impulsivity or other behavioral issues. Further review of the record did not identify a formal behavior plan. The use of Abilify, Zyprexa, Trazodone, Clonidine and Melatonin were not included in a formal behavior plan for client #6. Interview on 6/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 did not have a behavior plan available for review which incorporated the use of his behavior medications.	W 312		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 4 audit clients (#5 and #6) received vision and hearing examinations as indicated. The findings are: A. Review on 6/22/21 of client #5's record revealed a visual examination had been	W 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 323	Continued From page 6	W 323		

completed on 11/27/19. Additional review of the report indicated a recommendation for a "Yearly exam". Further review of client #5's record did not include a current visual examination. Review of the client's Individual Program Plan (IPP) dated 3/24/21 noted, "Ophthalmology to be completed as recommended by MD."

Review on 6/22/21 of client #5's record revealed an audiological examination had been completed on 5/29/18. No current audiological examination could be located. Additional review of client #5's IPP dated 3/24/21 noted, "Audiological exam to be completed every 2 years unless otherwise noted by MD."

Interview on 6/22/21 with the Site Supervisor confirmed client #5 was in need of an audio and visual examination; however, these appointments have not been scheduled as of the date of the survey.

Interview via phone with the facility's nurse on 6/22/21 revealed each client's audio and/or visual examination should be completed as indicated in their IPP or as recommended by the doctor.

B. Review on 6/22/21 of client #6's record revealed he had been admitted to the facility on 5/13/20. Additional review of the record did not include an audio or visual examination.

Interview on 6/22/21 with the Site Supervisor confirmed client #6 was in need of an audio and visual examination; however, these appointments have not been scheduled as of the date of the survey.

Interview via phone with the facility's nurse on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 323	Continued From page 7 6/22/21 revealed each client's audio and/or visual examination should be completed as indicated in their IPP or as recommended by the doctor.	W 323		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure each client received comprehensive dental services including periodic examinations at least annually. This affected 2 of 4 audit clients (#5 ans #6). The findings are: A. Review on 6/22/21 of client #5's record revealed his last dental examination and cleaning had occurred on 7/19/19. No current dental examinations could be located. Interview on 6/22/21 with the Site Supervisor confirmed client #5 was in need of a dental examination; however, his appointment has not been scheduled as of the date of the survey. B. Review on 6/22/21 of client #6's record revealed he had been admitted to the facility on 5/13/20. Additional review of the record indicated no dental examination or cleaning had been completed since his admission. Interview on 6/22/21 with the Site Supervisor confirmed client #6 was in need of a dental examination; however, his appointment has not	W 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 352	Continued From page 8 been scheduled as of the date of the survey.	W 352		
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5 received comprehensive dental treatment services for restoration of teeth and maintenance of his dental health. This affected 1 of 4 audit clients. The finding is: Review on 6/22/21 of client #5's record revealed the following dental visits and findings: 7/19/19 - Periodontal disease, Oral Hygiene - Fair, "General anesthesia in hospital - needs multiple root canals and crowns to restore his mouth." 12/2/19 - "...patient needs extreme treatment with crowns and root canal. Medicaid will not cover crowns, so longer fillings will be used." Recommendations: "Provide treatment in hospital setting and provide longer fillings where possible and extract any teeth that cannot be treated." Additional review of the record did not reveal any further dental treatment had been provided to address his dental concerns.	W 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 356	Continued From page 9 Interview on 6/22/21 with the Site Supervisor and management staff indicated the client has not returned to the dentist to complete the recommended dental work due to the halt in dental surgeries as a result of the COVID-19 pandemic. Additional interview revealed no alternative dentist has been contacted and no appointment has been scheduled as of the date of the survey.	W 356		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #4 was furnished adaptive equipment identified as needed. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 6/21 - 6/22/21, client #4 did not wear eyeglasses. The client was not prompted or assisted to wear eyeglasses. Review on 6/22/21 of client #4's Individual Program Plan (dated 4/7/21) revealed a vision examination report dated 4/9/19. The report noted the client has "very mild hyperopia and presbyopia" and "Needs full time wear glasses for	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 436	Continued From page 10 presumed amblyopia (right) eye". The report included a recommendation for "Full time wear specs". Additional review of client #4's record did not include any further information regarding eyeglasses. Interview on 6/22/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he was not aware of client #4 having eyeglasses and the team had not discussed his need for eyeglasses as identified at his last vision appointment.	W 436		
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 client #4 received his specially-prescribed diet as indicated. This affected 1 of 4 audit clients. The finding is: During 3 of 3 meal observations in the home on 6/21 - 6/22/21, client #4 did not receive double portions of meal items. With the exception of two sausage patties served at the breakfast meal on 6/22/21, the client was not assisted to serve himself double portions. Interview on 6/22/21 with Staff B revealed menus and each client's diet is posted in the kitchen of the home. Review on 6/21/21 of client #4's Individual	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G269	A. BUILDING _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY II GROUP HOME	322 HICKORY AVE SANFORD, NC 27330

(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 11 Program Plan (dated 4/7/21), the client's nutritional evaluation (dated 2/3/21) and a diet list (updated 4/2/21) posted in the kitchen revealed he receives a regular diet with "double portions". Interview on 6/22/21 with the Site Supervisor confirmed client #4 should receive double portions at meals as indicated.	W 460		