STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of program implementation. This affected 1 of 5 audit clients (#4). The findings are: A. The facility failed to follow client #4's feeding guidelines. For example: During observations in the home on 5/19/25 at 5:31pm, client #4 was observed eating dinner, which consisted of graham crackers, a container of yogurt, and a cup of milk. At no time during the observation was client #4 offered any food items from the dinner menu. During additional observations in the home on 5/20/25 at 7:03am revealed client #4 eating breakfast, which consisted of graham crackers, yogurt and a cup of milk. At no time during the observation was client #4 offered any food items from the breakfast menu.	W 249	RECEIVED JUN 02 2025 DHSR-MH Licensure Sect QIDP will have nutrition assesment updated. Client will be offered a non preferred food at meals with his preferred food. Staff will be reinserviced to ensure non preferred food are being given to client. QIDP will montior quarterly. QA will monitor monthly. GHD will monitor weekly.	5/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Love — TITLE: QIDP — (X6) DATE: 5/27/25

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
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 Review on 5/20/25 of client #4's Individual Program Plan (IPP) dated 3/14/25 revealed client #4 is supported with feeding guidelines, which states, "It is important to encourage 1 - 2 bites of menu items before deferring to preferred foods." Interview on 5/20/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should be offered items from the menu and prompted to eat 1 -2 bites before being offered his preferred food items. B. The facility failed to implement client #4's Positive Behavior Support Plan (PBSP). For example: During observations in the home on 5/19/25 at 4:34pm, client #4 was observed standing at the dining room table, playing a game on his iPad. Staff A and Staff B were in the dining room at the time of the observations. Client #4 was observed to repeatedly put his hands down the front of his pants. At no point did staff redirect client #4 to prompt him to stop, prompt him to go to his room or offer him another activity. Review on 5/20/25 of client #4's PBSP dated 5/2/25 revealed target behaviors consisting of resistance, face slapping, self-scratching, inappropriate access of foods, leaving a supervised area, and putting his hands down his pants. Continued review of the PBSP revealed the following interventions related to putting his hands down his pants: 1. Monitor him to offer him an alternative activity, location or socialization. 2. Ask if he needs a bathroom break, help with anything, or assistance in getting started on something.	W 249	Staff will be re-inserviced on clients behavior program to make sure they are redirecting client when hands are in pants. Staff will redirect, give alternative activity, encourage a change in location and have client wash hands. This will be monintored by QIDP quarterly, QA monthly, and GHD weekly.	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 3. Staff will redirect him to his tablet or phone. If he does not respond, ask if he wants to go to his bedroom. 4. If he continues, let him know he needs to go to his room for personal time. Check on him within 15 minutes and return him to his daily schedule. 5. Assist him to have good hygiene and to appropriately wash his hands. Interview on 5/20/25 with the QIDP confirmed staff should follow the intervention steps when client #4 is displaying the target behavior of putting his hands down his pants.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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 interviews, the facility failed to ensure all staff were sufficiently trained in health and hygiene methods to prevent cross contamination. This potentially affected 2 of 5 audit clients (#1 and #3). The finding is: During observations in the home on 5/20/25 at 7:03am, Staff A was observed in the kitchen cooking eggs and putting slices of bread on plates. Continued observations revealed Staff A to touch various surfaces in the kitchen, and pick up a chair from the office and bring it into the dining room. At 7:14am, Staff A was observed to feed client #3. At 7:17am, Staff A was observed to use her bare hands to tear off pieces of client	W 340	All staff will be re-inserviced on proper food preparation and serving of meals ensuring appropriate hand hygiene, and glove use. Training will occur in the homes. Food prep and serving of meals will observed and documented by nursing in each home weekly to ensure appropriate health and hygiene measures are being taken. Nursing director will observe and document mealtime in one home monthly. Re-inservices will occur immediately when necessary.	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 3 #1's toast and hand feed her the pieces, continuing to use her bare hand. At no time during the observation was Staff A observed to wash her hands. Interview on 5/20/25 with the Qualified Intellectual Disabilities Professional (QIDP) and facility nurse revealed Staff A should have washed her hands before feeding clients #1 and #3, and should have used a utensil to feed client #1 her toast.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medications without error for 1 of 5 audit clients (#4). The finding is: During morning observations in the home on 5/20/25 at 7:05 AM revealed Staff C to prepare medications to give to client #4 and had a cup of almond milk sitting on the counter. Further observations revealed staff to administer vitamin D (tablet crushed), docu liqu 5ml and gavilax powder one capful into client #4's cup of almond milk. Continued observations revealed Staff C to verbally prompt client 4 to dink his milk, while exiting the medication room. Subsequent observations at 7:30 AM revealed client #4 to sit at the dining table to consume his breakfast meal. Additional observations at 8:05 AM revealed Staff C to verbally prompt client #4 to bring the dishes to sink and emptied his cup	W 369	All med techs will be re-inserviced on proper administration of medication mixed in food or liquid. Med techs must stay with the resident until all medication has been taken. Med pass will be observed and documented weekly by nursing to ensure all medication is being given, making sure those which are mixed with food or liquid are receiving meds as prescribed. Nursing director will observe and document med pass in one home monthlhy. Re-inservice will occur immedidately when necessary.	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 369	Continued From page 4 with the almond milk mixed with his medications. At no point during observations did staff prompt the client to consume the remainder of his almond milk mixed with his medications. Review of record on 5/20/25 of client #4's physician's order revealed to mix docu liqu and gavilax powder with 8 ounces of water and drink every morning at 8:00 AM. Further review revealed client's medications may be crushed. Interview with the facility nurse on 5/20/25 revealed the client's physician order is current. Further interview revealed staff should ensure that the client consumed all of his medications as prescribed.	W 369		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure food was served in a form consistent with the developmental level for 3 of 5 audit clients (#1, #2 and #5). The findings are: A. During observations in the home on 5/19/25 at 5:31pm, client #2 was observed eating his dinner, which consisted of two chicken breast filets served in whole form, sweet baby carrots served in whole form, and rice. Client #2 was observed to use a knife to cut the two chicken breast filets into 4 large pieces each. At no time during the observation did staff prompt client #2 to cut his chicken into smaller, bite size pieces or to cut his carrots into bite size pieces.	W 474	Staff will be ire-inserviced to monitor client to ensure foods are cut into correct bite sized consistency. If client cuts food and it's not the correct consistency then redirect the client to cut the food into smaller bites. This will be monitored by QIDP quarterly, QA,montly, GHD weekly	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 474	Continued From page 5 During additional observations in the home on 5/20/25 at 7:14am revealed client #2 eating breakfast, which consisted of scrambled eggs and a piece of toast, served whole. At no time was client #2 observed to cut his toast into bite size pieces nor was staff observed to prompt him to cut his toast into bite size pieces. Review on 5/19/25 of client #2's Individual Program Plan (IPP) dated 6/21/24 revealed a diet order consisting of regular, 1800 calories, bite sized, sandwiches cut in half, thin liquids, seconds of fruits and vegetables at lunch and dinner, and limit sodas to 16 ounces of diet soda daily. Continued review of client #2's IPP revealed feeding guidelines, which states: "Bite sized foods, sandwiches cut in half. Allow him to practice cutting up the food, if he is having difficulty ask him if you can assist him. Sit upright in wheelchair or regular supported chair with a 70 - 90 degree bend at the waist." Interview on 5/20/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #2 can cut his food, as needed. Continued interview with the QIDP confirmed that staff should have prompted client #2 to cut his food into bite size pieces. B. During observations in the home on 5/19/25 at 5:31pm, client #1 was observed eating her dinner, which consisted of two chicken breast filets served in whole form, sweet baby carrots served in whole form, and rice. Further observations revealed Staff A to cut client #1's chicken breast filets and carrots with a spoon,	W 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 474	Continued From page 6 then feed to client. Continued observations revealed client #1 to slowly consume the dinner meal. At no point during observations was client #1's dinner meal served as 1500 calorie mechanical soft (minced). Observations during the breakfast meal on 5/20/25 at 7:00 AM revealed client #1 to sit at the dining table. Further observations at 7:15 AM revealed client #1 to participate in the breakfast meal which consisted of scrambled eggs, toast and milk. Continued observations revealed Staff A to feed client #1 scrambled eggs with a small maroon spoon. Subsequent observations revealed Staff A to put a slice of toast in client's mouth with her bare hand and have client bite pieces off to eat. At no point during the observation was client #1 breakfast meal served as 1500 calorie mechanical soft (minced). Review of record on 5/20/25 for client #1 revealed a Nutritional Assessment (NA) dated 9/20/24. Further review revealed client's diet listed as 1500 calorie mechanical soft (minced) with thin liquids. May have bite sized snacks, if difficulty offer food minced. Seconds of vegetables only. Avoid tomato and spicy products, nuts, seeds, dried fruits, who cuts of firm meat. No prune juice, dilute soda by half with water, limit gassy vegetables such as broccoli and cauliflower. Interview with the facility nurse on 5/20/25 verified client #1's diet is current and staff should serve client's meals as prescribed. C. During observations in the home on 5/19/25 at 5:31pm, client #5 was observed eating her dinner, which consisted of two chicken breast	W 474	Re-inservice staff to bring food out whole for client to see and then take back to the kitchen and blend to minced consistency before feeding food to client. Staff will need to use proper utinsels to feed and if you have to pick up an item you should have gloves on and not use bare hands. This will be monitored by QIDP quarterly, QA monthly, and GHD weekly.	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 474	Continued From page 7 filets served in whole form, sweet baby carrots served in whole form, and rice. Continued observations revealed Staff A to separate client #5's chicken breast filets with both hands while wearing gloves. Further observations revealed client #5 to slowly consume the dinner meal. At no point during observations was client #5's dinner meal served as 1500 calorie, bite sized minced meats. Observations during the breakfast meal on 5/20/25 at 7:00 AM revealed client #5 to sit at the dining table. Further observations revealed client #5 to participate in the breakfast meal which consisted of scrambled eggs, toast and milk. Continued observations revealed client #5 to consume her breakfast toast in whole pieces. At no point during the observation was client #5 breakfast meal served as 1500 calorie, bite sized minced meats. Review of record on 5/20/25 for client #5 revealed a NA dated 4/18/25. Further review revealed a diet listed as 1500 calorie, bite sized and minced meats, with low calorie beverages. Utilize a protein shake smoothie as a meal replacement when she is not in the mood for a menu item. Interview with the facility nurse on 5/20/25 verified client #5's diet is current and staff should serve client's meals as prescribed.	W 474	Staff will be re-inserviced to make sure client gets bite sized minced meats . Staff will also monitor to make sure that client cuts her own foods to bite sized consistency. If she cuts the foods to large staff will redirect client to recut food down to smaller size. Staff will make sure meats are minced. This will be monitiored by QIDP quarterly, QA monthly, and GHD weekly.	5/27/2027
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 and interview, the facility failed to ensure all appropriate utensils were	W 475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 8 provided to 1 of 5 audit clients (#5). The finding is: Observations during the dinner meal on 5/19/25 at 5:15 PM revealed all clients to sit at the dinner table. Further observations revealed client #5 to participate in the dinner meal which consisted of chicken breast filets, sweet baby carrots, and rice with a spoon only. Continued observations revealed client #5 to request a knife to cut her chicken and was told by staff that she couldn't have one. At no point during the observation did staff offer a full place setting for clients #5 consisting of a fork, spoon, and knife during the dinner meal. Observations during the breakfast meal on 5/20/25 at 7:00 AM revealed client #5 to sit at the dining table. Further observations revealed client #5 to participate in the breakfast meal which consisted of scrambled eggs, toast and milk with a spoon only. At no point during the observation did staff offer a full place setting for client #5 of a fork, spoon, and knife during the breakfast meal. Review of record for client #5 on 5/20/25 revealed a plan of care dated 4/18/25. Further review of the plan of care revealed client's feeding skills, uses utensils correctly, feeds self with fingers. Continued review of the client's record revealed an occupational therapy (OT) evaluation dated 11/12/24 which states client #5 uses the following utensils at mealtime: spoon, fork, and knife. Subsequent review of the OT evaluation revealed client #5 can cut her own food to bite size consistency. Client attempts this tasks and then receives staff assistance as needed. Interview with the facility nurse on 5/20/25 verified	W 475	Staff will be re-inserviced to ensure that all residents have appropriate utensils for each meals. Monioring by QIDP quarterly, QA monthly, and GHD weekly.	5/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G153	A. BUILDING _____ B. WING _____	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHELM PLACE HOME	630 WILHELM PLACE CONCORD, NC 28026

(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 that client #5 can use regular utensils during mealtimes and should have received a full place setting during meals.	W 475		