STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G062	A. BUILDING _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOXWOOD ACRES	3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028

(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 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004	E004 The Qualified Professional will ensure the EPP for Boxwood is in the home and available to all staff and will in-service all staff on the EPP. The clinical team will monitor through environmental assessments 1x a week for a period of 30 days and then on a routine basis to ensure the EPP is available in the home to all staff. In the future, the qualified professional will ensure the EPP is in the home and trained to all staff.	8/18/25

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

IDD Regional Administrator 6/24/25

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.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the emergency preparedness plan (EPP) was reviewed and updated at least every two years relative to client specific information. The finding is: Review of facility documentation on 6/18/25 revealed an EPP dated 4/25/25. Further review of the facility EPP did not reveal evidence of client specific information for two clients (#1, #4). Continued review of the facility EPP contained client information relative to two clients who have been discharged. Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 verified that client specific information should be updated when new admissions and discharges occur. Further interview with the QIDP revealed client specific information for client #1 and #4 should have been added to the facility EPP in a timely manner after admission to the facility.	E 004		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	E 039		

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E 039	Continued From page 2 *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039	E039 The Qualified Professional and Safety Chairperson will update the Emergency Preparedness Plan. The Qualified Professional will train all staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan every 6 months to ensure it remains updated and staff are trained. The Program Manager and Safety Chairperson will organize and complete a tabletop exercise. The Safety Chairperson will monitor to ensure tabletop exercises are completed at least on an annual basis. In the future, the Regional Administrator will ensure tabletop exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plan is updated and staff are trained on the current plan and training conducted annually.	8/18/25

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E 039	Continued From page 3 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient	E 039		

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E 039	Continued From page 4 care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:	E 039		

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E 039	Continued From page 5 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 6 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 7 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 8 the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the	E 039		

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E 039	Continued From page 9 emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 10 (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to show evidence of exercises to verify testing of the emergency preparedness plan (EPP). The finding is: Review of facility documentation on 6/18/25 revealed an EPP dated 4/25/25. Further review of the facility's EPP did not reveal evidence of a mock drill, tabletop exercise, or full-scale community-based exercise to test the facility's EPP. Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 revealed that evidence of a tabletop exercise, mock drill, or full-scale exercise could not be found during the survey. Further interview with the QIDP revealed a live event was discussed, however, the	E 039		

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E 039	Continued From page 11 documentation could not be found. Continued interview with the QIDP verified that staff and management should complete all emergency preparedness exercises to test the EPP as required.	E 039		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted timely. The finding is: Observations in the group home during the survey period from 6/17/25 - 6/18/25 revealed the following items on the patio: a broken wooden chair, two 5-foot plastic LED light covers, a portable standing toilet seat and metal free standing towel stand. Continued observations revealed no current work orders submitted for items to be picked up. Review on 6/17/25 - 6/18/25 of the facility's work orders revealed no orders for the items to be discarded. Interview with staff A on 6/18/25 revealed they have made management aware of the items that need to be picked up, but they have not completed any work orders. Interview with the qualified intellectual disabilities professional (QIDP) on 6/10/25 revealed she is	W 104	W104 The business manager will in-service the maintenance coordinator on completing work orders in a timely manner. The clinical team will monitor through environmental assessments 2x a week for a period of 30 days and then on a routine basis to ensure all work orders are completed. In the future, the maintenance coordinator will ensure all work orders are completed in a timely manner.	8/18/25

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W 104	Continued From page 12 aware of the items that need to be picked up. Further interview the QIDP revealed management should be placing orders for the items to be hauled away.	W 104		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure 1 of 6 audited clients (#1) exercise rights as clients and citizens relative to dignity. The finding is: Observation in the home on 6/18/25 at 7:25 AM for client #1 revealed staff G to instruct her to stand while staff G placed a green pad on the love seat underneath her; then instructed her to return to her seated position. Continued observation for client #1 revealed her to indicate her stomach hurt. Further observation for client #1 revealed staff G to instruct her to go to the bathroom. Subsequent observation of client #1 revealed her to return to the living room and announced to staff G that she felt better from her bathroom visit. Review of records on 6/18/25 for client #1 revealed a person-centered plan (PCP) dated 12/17/24. Continued review of client 1's PCP revealed goals to take trash out, replace bag and wash hand and use appropriate manners. Further review of records for client #1 revealed a	W 125	W125 The qualified professional will implement a toileting program for client #1 and will in-service all staff on the new program. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure the new toileting program is followed. In the future, the qualified professional will ensure programs are created for identified areas of need.	8/18/25

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W 125	Continued From page 13 behavior support plan dated 4/2/24 with target behaviors of physical aggression, verbal aggression, refusal, property destruction, leave area without notice - (LAWN), food obsession, nudity, fecal smearing, pacing and parnola. Interview on 6/18/25 with the qualified intellectual disabilities professional (QIDP) confirmed that client #1 can let staff know when they need to use the restroom. Continued interview with the QIDP revealed two words that staff and client #1 use to indicate when she needs to have a bowel movement or urinate. Further review of the BSP listed strategies staff could use for preventive and reinforcement procedures to further foster communication with her toileting success. Subsequent interview with the QIDP confirmed client #1 would benefit from a new learning objective focused on the use of her behavioral strategies.	W 125		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure clients have a right to personal privacy for 1 of 3 audited clients (#4) during personal care. The finding is: Morning observations on 6/18/25 at 7:00AM revealed a video monitor belonging to client #4 to be positioned in the living room area in the "on" position. Further observations revealed the video monitor to view staff providing personal care to client #4 in his room. Continued observation at	W 129		

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W 129	Continued From page 14 7:12AM revealed staff to transfer client #4 from his room to the bathroom without any pants. Additional observation at 7:19AM revealed staff to exit the bathroom door leaving client #4 exposed and toileting with the door open. Subsequent observations at 7:30AM revealed the video monitor to remain on while client #4 was receiving personal care in his room. At no point during the observations did staff ensure client #4 received privacy during personal care. Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 verified that the video monitor for client #4 should be turned off during awake hours. Further interview with the QIDP revealed the video monitor is to be used at night due to the client's seizure disorder diagnosis. Continued interview with the QIDP revealed staff have been trained on respecting clients' privacy during personal care.	W 129	W129 The qualified professional will in-service all staff on the use of video monitors and ensuring the privacy of People Supported. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure video monitors are used as ordered. In the future, the qualified professional will ensure all staff are trained on the use of video monitors.	8/18/25
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 review and interviews, the facility failed to ensure that a continuous active treatment program consisting	W 249		

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W 249	Continued From page 15 of needed behavioral interventions were implemented as identified in the person-centered plan (PCP) for 1 of 3 audited clients (#1). The finding is: Observations throughout the recertification survey from 6/17/25 - 6/18/25 revealed client #1 to attempt to communicate with staff speaking in the Portuguese language. Further observations revealed client #1 to participate in various activities to include mealtimes, medication administration, personal care, chores, and other activities while attempting to communicate with various staff. Continued observations revealed client #1 to become agitated and raise her voice to staff and surveyors while communicating in Portuguese. At no point during the observation did staff provide client #1 with a digital translation device to assist with translation from Portuguese to English. Review of the record for client #1 on 6/18/25 revealed a PCP dated 12/17/24 and behavior support plan dated 1/10/25 which indicated staff should be aware the client has a language barrier. Further review of the 1/2025 BSP indicated client #1 becomes easily frustrated and may yell/scream/repetitively say a phrase when she feels she is not being heard or understood. Additional review of the 1/10/2025 BSP indicated staff should offer client #1 a digital translator to communicate with the client more effectively, "but that does not always help and can cause more confusion or agitation". Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 revealed staff have been trained to use a digital translation device or "google translator" application if the	W 249	W249 The behavior analyst will in-service all staff on the behavior support plan for client #1. The clinical team will monitor through interaction assessments 2x a week for a period of 30 days and then on a routine basis to ensure the BSP is followed as written. In the future, the behavior analyst will ensure all staff are trained on the BSPs of People Supported.	8/18/25

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W 249	Continued From page 16 client refuses to use the translation device. Further interview with the QIDP verified that client #1 has a communication book with keywords and short phrases to use to improve communication between staff and the client. Continued interview with the QIDP revealed staff should have provided the communication interventions as indicated in client #1's BSP as prescribed.	W 249		
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 interviews, the facility failed to ensure that adaptive equipment was used appropriately for 1 of 6 audited client (#3) during mealtimes. The finding is: Afternoon observations on 6/17/25 at 4:50PM revealed client #3 to be prompted to the dining table to prepare for the dinner meal. Further observations revealed client #3 to participate in the dinner meal using the following adaptive equipment: shirt protector, high sided dish, and dycem mat. At no point during the observation was client #3 provided a maroon spoon during the dinner meal. Morning observations on 6/18/25 at 6:50AM revealed client #3 to participate in the breakfast meal without a maroon spoon provided.	W 436	W436 The qualified professional will in-service all staff on the adaptive equipment of People Supported. The clinical team will monitor through meal time assessments 1x a week for a period of 30 days and then on a routine basis to ensure adaptive equipment is being utilized as ordered. In the future, the qualified professional will ensure all staff are trained on adaptive equipment.	8/18/25

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W 436	Continued From page 17 Review of the record for client #3 on 6/18/25 revealed a physician's order dated 6/11/25 which indicated the client has the following adaptive equipment to be used during mealtimes: maroon spoon, straw (PRN), non-skid mat, high sided dish, and shirt protector. Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 verified client #3 should have been provided a maroon spoon during mealtimes. Interview with the QIDP revealed staff have been trained to provide client #3 with adaptive equipment as prescribed.	W 436		
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 observation, record review, and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 2 of 6 audit clients (#4 and #6). The findings are: A. The facility failed to assure food was served in the right consistency for client #4. prescribed. For example: During observations in the home on 6/18/24 at 7:57 AM, client #4 was observed eating breakfast which consisted of 1 small muffin, 6 oz yogurt, 1/4 cup diced strawberries, 8 oz orange juice, 8 oz -2% milk, and water. The small muffin served in chunks with client #4 eating all in that form. Review on 6/18/25 of client 4#'s nutritional assessment (NA) dated 11/17/23 revealed a diet	W 474	W474 A & B. The qualified professional will in-service all staff on the prescribed diets of People Supported. The clinical team will monitor through meal time assessments 1x a week for a period of 30 days and then on a routine basis to ensure prescribed diets are being followed as ordered. In the future, the qualified professional will ensure all staff are trained on the prescribed diets.	8/18/25

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W 474	Continued From page 18 order consisting of ¼-inch consistency. B. The facility failed to assure food was served at the right consistency for client #6. prescribed. For example: During observations in the home on 6/10/25 at 5:00 PM, client #6 was observed with a deep dish divided plate which consisted of his dinner meal of the following: 3 oz baked chicken, ¼ cup of potato salad, ½ cup collard greens, 8 oz water and 8 oz - milk. Continued observation revealed client #6's dish to have some chunks of chicken mixed in with his ground chicken. Further observation revealed client #6 to refuse his meal and beverages but staff A presented his meal containing some ground portions not processed to ground consistency as prescribed. Review on 6/18/25 of client 6#'s physician's order (PO) dated 6/18/25 revealed a diet order consisting of ¼ consistency diet. Interview on 6/18/25 with the qualified intellectual disabilities professional (QIDP) confirmed both client's NAs are current. Further interview with the QIDP confirmed both clients' diet orders should have been followed.	W 474		