STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 and interviews, the facility failed to ensure that privacy was maintained for 1 of 6 audited clients (#10) during personal care. The finding is: Observations on 1/7/26 at 8:20 AM revealed the residential manager (RM) to propel client #10 to his room to prepare and receive a breathing treatment. Further observations revealed the RM to request client #2 to come to client #10's room to assist with turning his television on. Continued observations revealed client #2 to enter the room and begin working on getting client #10's television to work. Subsequent observations revealed the RM to connect client #10 to the breathing machine while client #2 was in the room. Interview on 1/7/26 with the facility nurse revealed all clients should maintain privacy while receiving personal care.	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 assure the plan of care (POC) for 1 of 6 audited clients (#9) included training for rate of eating. The finding is:	W 227		

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

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W 227	Continued From page 1 Observations in the group home on 1/6/26 at 5:23 PM revealed client #9 to participate in the dinner meal consisting of eight chicken fingers and approximately 10 french fries. Further observation throughout the meal revealed client #9 to eat all of his french fires at a fast rate while laughing and engaging in loud vocalizations. Continued observation of the dinner meal revealed client #9 to place the entire chicken finger in his mouth while laughing and making loud vocalizations, one after the other, at a fast rate until all were consumed. Subsequent observation revealed staff and client #9's peers to repeatedly instruct him to stop yelling while eating and to use an inside voice. Review of records on 1/7/26 for client #9 revealed a Nutritional Assessment (NA) dated 4/7/25 that revealed a 2000 calorie regular diet and regular liquids. Continued review of records revealed an Occupation Therapy Assessment (OT) dated 6/17/25 that revealed client #9's have a 2000 calorie regular diet with regular liquids and requires prompts to slow rate of eating. Interview on 1/6/26 with the facilities registered nurse (RN) and Qualified Intellectual Disabilities Professional (QIDP) verified both assessments to be current. Further interview with the RN and QIDP verified client #9 does require staff redirection to slow rate of eating. Continued interview with the QIDP revealed client #9 could benefit from programming to address rate of eating to reduce his risk of choking.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 2 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 client received a continuous active treatment program consisting of needed interventions and services as identified in the Plan of Care (POC) in the area of adaptive equipment implementation. This affected 1of 6 audited clients (#1). The finding is: Observations in the group home during the recertification survey on 1/6/26 - 1/7/26, revealed client #1 to sit in his wheel chair slightly leaning forward. Further observations revealed client #1 to participate in leisure activities, dinner and breakfast meals and medication administration with his chest straps worn under his arm. Continued observations did not reveal staff to check or correct client #1's chest strap to ensure he was secured correctly, sitting in an upright position. Review of record on 1/7/26 for client #1 revealed a POC dated 2/14/25. Further review of the record revealed a physical therapy evaluation dated 6/17/25. Continued review revealed client #1's wheelchair has a chest strap to assist with sitting in an upright position.	W 249		

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W 249	Continued From page 3 Interview with the facility nurse on 1/7/26 at 8:15 AM confirmed client #1's chest straps should be worn over his shoulders and corrected how it should be worn. Further interview with the nurse revealed that client #1 has a tendency to get out of his chest straps and wears it under his arm. Interview on 1/7/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client's #1 POC and PT evaluation to be current. Further interview with the QIDP revealed client #1's chest strap should be secured to assist with sitting in an upright position. Continued interview with the QIDP revealed client #1 has been known to get out of his chest strap and wear it under his arms. Subsequent interview with the QIDP revealed client #1's chest strap should be worn as prescribed.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: The facility failed to assure techniques to manage inappropriate behavior were not used for the convenience of staff for 2 of 6 audited clients (#5 and #8) as evidenced by observation and interview. The findings are: Observations in the group home on 1/6/26 at 4:30 PM revealed the bathroom adjacent to the dining room to have no hand soap, paper towels, or toilet paper in the bathroom. Further observations at 6:00 PM revealed staff A to assist client #8 in a bathroom adjacent to the home's dining room.	W 287		

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W 287	Continued From page 4 Continued observations revealed staff A to leave the bathroom to provide client #8 privacy. Subsequent observations at 6:11 PM revealed staff A to return to the bathroom with only gloves applied to her hands and to exit with client #8 and no gloves on her hands. Additional observations at 6:15 PM revealed client #5 to enter the bathroom adjacent to the home's dining room with no supplies and exit after use. Observations in the group home on 1/7/26 at 7:51 AM revealed client #5 to enter the bathroom adjacent to the dining room and close the door. Further observations at 7:55 AM revealed client #5 to open the door and a peer to call for the residential manager (RM) to assist the client. Continued observations revealed the RM to gather an Attend, Sani-wipes, toilet wipes and gloves and enter the bathroom closing the door. Subsequent observations revealed the RM and client #5 to exit the bathroom. Interview on 1/7/26 with the RM and Qualified Intellectual Disabilities Professional (QIDP) revealed supplies consisting of hand soap, paper towels, toilet paper and wipes of any kind are not kept in the bathroom adjacent to dining room due to client #5's behaviors. Further interview revealed staff should ensure hygiene products are accessible for all clients in all bathrooms at all times.	W 287		