STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMAN GROUP HOME	**104 TEAL STREET , HOFFMAN, North Carolina, 28347**

(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
W0249	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 areas of self-help/domestic tasks and adaptive equipment use. This affected 2 of 3 audit clients (#4 and #5). The findings are: A. During observations throughout the survey on 6/8 – 6/9/26, client #5 did not wear a helmet. The client was not assisted to wear a helmet at any time. Review on 6/9/26 of client #5's Behavior Support Plan (BSP) dated 4/1/26 revealed an objective to address physical aggression, self-injury and disruption. Additional review of the plan noted under Helmet protocol, "[Client #5] has exhibited SIB without any antecedent. Therefore, the team agreed that during waking hours, [Client #5] should be asked to wear a protective helmet (as tolerated) during waking hours." Interview on 6/9/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 should be wearing his helmet as indicated in his BSP. B. During breakfast observations in the home on 6/9/26, Staff E proceeded to prepare a bowl of cereal for client #4, add jelly to her slice of toast and spread it for the client as she sat at the table. After the meal, Staff E removed various items from the table for the client. Client #4 was not prompted or	W0249		

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 reverse for further 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.

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

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W0249	Continued from page 1 assisted to complete these tasks. Interview on 6/9/26 with Staff E revealed client #4 can do a lot of things but she will often say she needs help or she can't do it. Review on 6/9/26 of client #4's IPP dated 8/5/25 revealed she needs help with her ADLs. Additional review of the client's Adaptive Behavior Inventory (ABI) dated 7/10/25 noted she can independently serve herself, identify cereals, and clear the table after meals. The ABI also indicated she has partial independence with preparing a breakfast meal and using a knife for spreading. Interview on 6/9/26 with the QIDP confirmed client #4 can do just about anything asked of her with assistance and encouragement from staff. C. During observations in the home on 6/9/26 after breakfast, Staff F cleared client #5's dirty dishes from the table without his assistance. Interview on 6/9/26 with Staff F revealed client #5 used to clear his dishes but does not anymore. Review on 6/9/26 of client #5's IPP dated 11/17/25 revealed, "[Client #5] can clear his place setting with assistance." Interview on 6/9/26 with the QIDP confirmed client #5 has the ability to clear his place setting after meals given assistance.	W0249		
W0340	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, document review and interviews, the facility failed to ensure all staff were trained regarding the appropriate use of gloves. The finding is: During meal preparation observations in the home throughout the survey on 6/8 – 6/9/26, Staff D and Staff E assisted client #2 and client #3 with food preparation tasks. During this time, clients and staff	W0340		

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W0340	Continued from page 2 wore gloves while completing all tasks. The gloves continued to be worn as the staff and clients touched and manipulated various items and surfaces including door knobs, handles, a trashcan lid, scissors, keys and a menu book. Interview on 6/9/26 with Staff E revealed she had been trained to wear gloves while completing meal preparation tasks. Review on 6/9/26 of the facility's infection control procedures (no date) revealed, "Employees will use gloves in accord with aseptic principles…Direct care staff will utilize all appropriate personal protective equipment when caring for service user. Direct care staff will also practice good handwashing after having initial contact with body fluids." Additional review of the procedures did not indicate gloves should be worn throughout meal preparation tasks. Interview on 6/9/26 with the Nurse B revealed staff have been trained to wear gloves when providing personal client care, coming in contact with bodily fluids or certain tasks performed during medication administration. Interview on 6/9/26 with the Qualified Intellectual Disabilities Professional (QIDP) indicated staff have not been trained to wear gloves while performing meal preparation tasks and gloves should be worn per facility policy.	W0340		
W0369	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 interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 4 clients (#3) observed receiving medications. The finding is: During observations of medication administration in the home on 6/9/26 at 7:51am, client #3 poured an undetermined amount of Miralax powder into the cap of the Miralax bottle. Closer observation of the powder noted it was well below the fill line of the bottle cap. As the Medication Technician (MT) watched, the client poured the powder from the bottle cap, into a liquid, stirred and consumed it.	W0369		

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W0369	Continued from page 3 Immediate interview with the MT indicated she did not notice the Miralax powder was not to the fill line of the bottle cap. Review on 6/9/26 of client #3's current physician's orders revealed an order for Miralax powder, mix 17gms (1 capful) in 8 ounces of water and take by mouth once a day at 8:00am. Interview on 6/9/26 with the Nurse A confirmed client #3's Miralax powder should be dispensed into the bottle's cap and filled to the fill line located inside of the bottle cap.	W0369		
E0037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E0037		

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E0037	Continued from page 4 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff,	E0037		

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E0037	Continued from page 5 individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first	E0037		

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E0037	Continued from page 6 workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure all staff received training on the Emergency Preparedness Plan (EPP). The finding is: Review on 6/8/26 of the facility's EPP (last reviewed on 4/8/26) revealed no documented staff training on	E0037		

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E0037	Continued from page 7 the plan. Interview on 6/9/26 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no documented training for the facility's EPP was available for review as of the date of the survey.	E0037		
W0460	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/document reviews and interview, the facility failed to ensure each client received their specially modified diets as indicated. This affected 2 of 3 audit clients (#4 and #5). The findings are: During breakfast observations in the home on 6/9/26 at 7:00am, client #4 and client #5 consumed whole slices of toast at the meal. The toast was not cut into smaller pieces. Both clients consumed the toast without difficulty. Review on 6/9/26 of a client diet list (dated 4/29/26) and Individual Program Plan (IPP) dated 8/5/25 revealed client #4 consumes a regular calorie diet with "1/2 inch pieces consistency". The diet list also noted client #5 should receive a 1500 calorie diet with his food in "1 inch consistency". Interview on 6/9/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 and client #5 should receive their food cut in the appropriate consistency as indicated.	W0460		