## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

PRINTED: 04/05/2018 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X3) DATE SUBVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING \_ B. WING 04/03/2018 34G175 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3801 US 117 NORTH **HIGHWAY 117 GROUP HOME** GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLÉTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) E 006 E 006 Plan Based on All Hazards Risk Assessment 6-1-18 CFR(s): 483.475(a)(1) - (2) Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1) - (2) The facility will progressively conduct and document a community and facility-based [(a) Emergency Plan. The [facility] must develop (all-hazards approach) risk assessment. and maintain an emergency preparedness plan that must be reviewed, and updated at least The facility will utilize information collected annually. The plan must do the following:] from the community and facility-based (allhazards) risk assessment to update current (1) Be based on and include a documented, emergency plan. facility-based and community-based risk assessment, utilizing an all-hazards approach. \* Staff will be progressively trained on hazards, risks, and strategies \*[For LTC facilities at §483.73(a)(1);] (1) Be based addressing emergency events identified by on and include a documented, facility-based and the risk assessment. community-based risk assessment, utilizing an allhazards approach, including missing residents. To promote efficiency, Nova will create a timeline for implementation at other facilities to meet \*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on globalization requirements. and include a documented, facility-based and community-based risk assessment, utilizing an allhazards approach, including missing clients. Responsible Persons: Nova's Leadership Council, Health & Safety Chairperson and Include strategies for addressing emergency (2)Committee, QP, RSS events identified by the risk assessment. Frequency/Monitoring: Reviewed at least \* [For Hospices at §418.113(a)(2):] (2) Include annually and updated as deemed necessary. strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide RECEIVED care. This STANDARD is not met as evidenced by: APR 1 6 2018 Based on record review and interview, the facility DHSR-MH Licensure Sect failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:

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

Condia Hell, Program Privator 4-9-18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**FORM** 

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-

0391

program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9JGF11

Facility ID: 922849

If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL	I TIPAF	DEPARTMENT OF HEALTH AND HUMAX等域 COM	figitation HOR MPLETED
			A. BUILDI	IVICES OMBINO		
			B. WING	00	CENTERS FOR MEDICARE & MEDICAID SEF	
NAME OF BE	OWNER OF OURDUIED	34G175				4/03/2018
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
HIGHWAY 117 GROUP HOME			1	BOLDSBORO, NC 27530	,	
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
E 006			E	006		6-1-18
	Continued From page	a 1			•	
		ve an emergency plan				
	based upon risk asse					
	revealed the plan did information in regards of the facility and the	he facility's current EP plan not provide specific s to the geographic location clients' needs of the facility nt, utilizing an all-hazards				
E 013	disabilities profession not aware of this specincluded in the EP pla Development of EP F CFR(s): 483.475(b)	Policies and Procedures	E	013	Development of EP Policies and Procedures CFR(s): 483.475(b)	
	develop and impleme policies and procedur plan set forth in parag assessment at parag and the communication this section. The policion	edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually.			The facility will progressively develop specific policies and update procedures to address emergency preparedness plans based upon the community and facility-based (all-hazard approach) risk assessment.  The facility will progressively develop specific policies and update procedures to address the development and maintenance of a primary an alternate communication plan.	es lee ds ic lee d
	*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical				The facility will develop policies and procedure relative to the management of medical an nonmedical emergencies.  Staff will be trained on policies and procedure relative to emergency preparedness plans.  Responsible Persons: Nova's Leadersh Council, Health & Safety Chairperson an Committee, QP, RSS	es ip

FOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES

APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	US	30-0391	
		Frequency/Monitoring: Reviewed at least annually and updated as deemed necessary.	
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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPA F FANSTELECTION COMPLETED				
			A. BUILDING _	<del>CENTERS FOR ME</del> DICARE & MEDICAI <mark>D</mark> SE	MEDICAID SERVICES OMB I	
		040475	B. WING00	938-0391	04/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	34G175	l s	TREET ADDRESS, CITY, STATE, ZIP CODE	04/03/2010	
			- 1	801 US 117 NORTH		
HIGHWAY	117 GROUP HOME		0	GOLDSBORO, NC 27530		
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	DATE	
				DEFICIENCY)		
E 013			E 013		6-1-18	
	Continued From pa	ge 2 emergencies, including,				
	but not limited to: Fi	re; equipment, power, or				
	water failure; care-r	elated emergencies; and				
	natural disasters lik	ely to threaten the health or				
		pants, staff, or the public.				
		ocedures must be reviewed				
	and updated at leas	t annually.				
	*IFor ESBD Facilitie	es at §494.62(b):] Policies and				
	_	alysis facility must develop and			]	
		ncy preparedness policies and				
		on the emergency plan set				
		a) of this section, risk				
		graph (a)(1) of this section,				
		tion plan at paragraph (c) of				
		licies and procedures must be				
	-	ted at least annually. These				
		e, but are not limited to, fire,				
	, , ,	r failures, care-related r supply interruption, and				
		ely to occur in the facility's				
	geographic area.	,				
		s not met as evidenced by:				
	Based on interview	, the facility failed to develop				
		d procedures to address				
		dness, considering risk				
	1	eir communication plan in				
		ncy evacuation of the clients in				
	the facility. The find	ing is:		•		
	During an interview	on 4/2/18, with management		·		
		ot have policies and				
		ally for the emergency				
	preparedness plan.			D	6-1-18	
E 032		leans for Communication	E 032	1	0-1-18	
	CFR(s): 483.475(c)	(૩)		Communication CFR(s): 483.475(c)(3)		
	(c) The [facility] my	st develop and maintain an		O: 11(3). 400.470(0)(0)		
		edness communication plan		The facility will update the current emerge	ncv l	
	cinorgono, propure	and a second second present		preparedness communication plan with prim		
				and alternate means of communication.		

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Staff will be trained on the updated emergency communication plan with primary and alternate means of communication.

Responsible Persons: Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS

Frequency/Monitoring: Reviewed annually and updated as deemed necessary.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A   DEPARTMENT OF HEALTH AND HUMA(X多時代を設定を)   COMPLETED   COMPLETED					
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1			CENTERS FOR MEDICARE & MEDICAL	SERVICES OMBIN		
			B. WINGO		ŀ		
NAME OF PE	ROVIDER OR SUPPLIER	34G175		STREET ADDRESS, CITY, STATE, ZIP CODE	04/03/2018		
NAME OF T	TOVIDEN ON BOLL EIEN		1	8801 US 117 NORTH			
HIGHWAY	117 GROUP HOME		3	GOLDSBORO, NC 27530			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION		
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	DATE		
	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)			
E 032			E 032		6-1-18		
	Continued From po	ge 3 that complies with					
	•	local laws and must be					
	•	ted at least annually.] The					
	•	n must include all of the					
	following:						
	(3) Primary and alte	ernate means for					
	communicating with						
	(i) [Facility] st		[				
		tate, tribal, regional, and local					
	emergency manage	ement agencies.					
	   *[For ICF/IIDs at §4	83.475(c):] (3) Primary and					
	_	communicating with the					
	ICF/IID's staff, Fede	eral, State, tribal, regional,					
		cy management agencies.					
		s not met as evidenced by:					
		station and interviews, the					
		elop an alternate means for n facility staff, regional and	1				
		during an emergency. The					
	finding is:	during air emergency. The					
	_						
	,	develop an alternate means					
		with staff, regional and local					
	governments during	g an emergency.					
	Review on 4/2/18 o	f the facility's emergency					
İ		did not include any					
	information regardi	ng alternate means of					
	communication.						
	During an interview	on 4/2/18, management					
	revealed if the land	line phone and cell service					
	1	as not another way to		,			
	communicate durin			CD Tuelulus Decement	6 1 40		
E 037			E 037	EP Training Program CFR(s): 483.475(d)(1)	6-1-18		
	CFR(s): 483.475(d	<b>从</b> "					
,			•	The facility will develop an emerge			
				training program for new and existing s	stati		

PRINTED: 04/05/20 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR **APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 All new and existing staff will be trained on an initial and annual basis according to the objectives identified in the training program. The facility will maintain documentation relative to training provided to staff. Responsible Persons: Nova's Leadership Council, Health & Safety Chairperson and Committee, QP, RSS Frequency/Monitoring: Initially, annually, and

as deemed necessary.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	- DEPARTMENT OF HEALTH AND HUM/ AFFRINTELICION	COMPLETED	
			A. BUILDING	CENTERS FOR MEDICARE & MEDICA	D SERVICES OMB	
			B. WING(	0938-0391		
NAME OF D	ROVIDER OR SUPPLIER	34G175	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	04/03/2018	
NAME OF P	HOVIDER OR SUPPLIER			3801 US 117 NORTH		
HIGHWAY	117 GROUP HOME			GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
E 037			E 03	7	6-1-18	
	ASCs, PACE orgar and dialysis facilitie  (i) Initial training policies and process	m. The [facility, except CAHs, nizations, PRTFs, Hospices, s] must do all of the following:  ng in emergency preparedness lures to all new and existing				
	arrangement, and vexpected role. (ii) Provide en at least annually. (iii) Maintain d	oviding services under volunteers, consistent with their nergency preparedness training ocumentation of the training. (iv) knowledge of emergency		·		
	at §491.12:] (1) Tra or RHC/FQHC] mu Initial training in em policies and proced staff, individuals pro	482.15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: (i) hergency preparedness dures to all new and existing poviding on-site services under volunteers, consistent with				
•	(ii) Provide en training at least and (iii) Maintain d	nergency preparedness nually. ocumentation of the strate staff knowledge of				
	hospice must do al (i) Initial train policies and proced employees, and ind arrangement, cons (ii) Demonstra procedures.	418.113(d):] (1) Training. The I of the following: ing in emergency preparedness dures to all new and existing hospice dividuals providing services under istent with their expected roles. ate staff knowledge of emergency				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPAF	DEPARTMENT OF HEALTH AND HUMA FRENTEBOTION CENTERS FOR MEDICARE & MEDICAI	COMPLETED	
		34G175	B. WING09	38-0391	04/03/2018
	ROVIDER OR SUPPLIER		38	FREET ADDRESS, CITY, STATE, ZIP CODE 301 US 117 NORTH OLDSBORO, NC 27530	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 037	employees (includin special emphasis pl procedures necessa others.  *[For PRTFs at §44 program. The PRTF (i) Initial training in epolicies and proced staff, individuals proarrangement, and vexpected roles.  (ii) After initial preparedness trainin (iii) Demonstration procedures.  (iv) Maintain depreparedness training	ew and rehearse its dness plan with hospice ag nonemployee staff), with aced on carrying out the ary to protect patients and  1.184(d):] (1) Training must do all of the following: emergency preparedness ures to all new and existing oviding services under colunteers, consistent with their training, provide emergency and at least annually. te staff knowledge of emergency	E 037		6-1-18
	organization must d Initial training in em policies and proced staff, individuals pro under arrangement, and volunteers, con roles. (ii) Provide er training at least ann (iii) Demonstra procedures, includir to do, where to go, an emergency. (iv) Maintain do	lo all of the following: (i) ergency preparedness ures to all new and existing oviding on-site services , contractors, participants, usistent with their expected mergency preparedness			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IA DEPARTMENT OF HEALTH AND HUMA 次多區程 的 FO (X2) MULTIPA F F A MORETED					
			A. BUILDII	D SERV	ICES OMB		
			B. WING _	_0	938-0391		
NAME OF P	ROVIDER OR SUPPLIER	34G175	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		03/2018
TO TWILL OF T	NOVIDEN ON OOF FEIEN				3801 US 117 NORTH		
HIGHWAY	117 GROUP HOME		į	(	GOLDSBORO, NC 27530		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	х	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)		DATE
E 037			Ε¢	037	7	**************************************	6-1-18
	Continued From pag	je 6					
	CORF must do all of	the following: (i) Provide					
		ergency preparedness					
		res to all new and existing					
		viding services under					
	_	olunteers, consistent with					
	their expected roles.						
	(ii) Provide eme training at least annu	ergency preparedness					
		cumentation of the					
	\ · · · /	trate staff knowledge of					
		res. All new personnel must					
		gned specific responsibilities					
		's emergency plan within 2					
		orkday. The training program					
	1	tion in the location and use of					
	1 -	signals and firefighting					
	equipment.						
	*iFor CAHs at §485.	625(d):] (1) Training program.					
	The CAH must do al						
	(i) Initial trainin	g in emergency preparedness					
		ıres, including prompt					
		uishing of fires, protection,					
		y, evacuation of patients,				:	
		ts, fire prevention, and					
	cooperation with fire authorities, to all new						
	1	wand existing stan, services under arrangement,					
		sistent with their expected			·		
	roles.	sictions man anon expected					
		ergency preparedness training					
	at least annually.						
	(iii) Maintain do	cumentation of the					
		trate staff knowledge of					
	emergency procedu	res.					
	*FT ON MI !O 1010	UF 000(4) 4 (4) Tool 1 To The					
		5.920(d):] (1) Training. The initial training in emergency					
	Own to must browde	anda daning in emergency					
I	I		1		1		1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	DEPARTMENT OF HEALTH AND HUMA以多氏科型8 (X2) MULTIPA F F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA 以多氏科型8 (X2) MULTIPA F A REPORT OF HEALTH AND HUMA NA			
			A. BUILDI	VICES OMB N			
		34G175		<del></del>		/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWAY	/ 117 GROUP HOME			ı	801 US 117 NORTH BOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 037		**************************************	E	037		6-1-18	
	and procedures to a individuals providing arrangement, and v their expected roles documentation of the demonstrate staff kn procedures. Therea provide emergency least annually.  This STANDARD is Based on interview failed to ensure dires.	olunteers, consistent with		337			
	plan (EP).  Review on 4/2/18 of no documented spe	ed training on the emergency  f facility documents revealed cific training for direct care					
	been trained regard drills; however, the	on 4/3/18 revealed they have ing fire drills and disaster staff could not provide specific e facility's EP program.					
W 154	disabilities profession care staff had been and disaster drills. If any formal training [EP.	with the qualified intellectual onal (QIDP) revealed direct trained regarding fire drills dowever, there had not been provided concerning the new	W	154	STAFF TREATMENT OF CLIENTS	6-1-18	
	CFR(s): 483.420(d)			.5-	CFR(s): 483.420(d)(3)  The investigative team will follow up and attempt to conduct an inquiry based on event reported on 12/9/17 and document findings.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR
APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO
0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPA	DEPARTMENT OF HEALTH AND HUMA (以為) FERNSTERCTION	TATE SUEVEY HO
	240175		A. BUILDING	<del>CENTERS FOR ME</del> DICARE & MEDICAID SE 938-0391	
NAME OF P	ROVIDER OR SUPPLIER	34G175		STREET ADDRESS, CITY, STATE, ZIP CODE	04/03/2018
	Y 117 GROUP HOME		:	9801 US 117 NORTH GOLDSBORO, NC 27530	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 154	are thoroughly investigations of an involving client (#1).  Client #1's injury of investigated.  Review on 4/2/18 of 12/9/17 involving cli "While [Client #1] wound check on him. When above his left brown what happened and know."Further revier revealed; "Approx. noted. Area cleaned Consumer stated he happened."  During an interview management confirmation conducted because some issues with st documentation was have been the causintellectual disabilities.	not met as evidenced by: and document reviews the conduct a thorough incident of unknown origin . The finding is: unknown origin was not  f an incident report dated ent #1, revealed the following: as taking a shower I went to n I walked in his forehead was bleeding. I asked him I he said that he didn't w of the incident report 1" cut above left eyebrow d and steri-strips applied. e didn't know how it  on 4/2/18 and 4/3/18, med the investigation was not client #1 had been having ability, however no available to support this could e of the incident. The qualified es professional (QIDP) erstood why the incident	W 154	· ·	6-1-18

		<i>*</i> .
•		
		,