DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	34G184		R 11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON REA DRIVE GROUP HOME	3747 BON REA DRIVE CHARLOTTE, NC 28266

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W 000	INITIAL COMMENTS Intake# NC00156629 As referenced, not all deficiencies were corrected on the follow-up (W189 and W249) and an additional deficiency was cited as part of the complaint investigation (W154).	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure an investigation was completed relative to an injury of unknown origin for client #6. The finding is: A review of internal documentation on 11/14/19 revealed nursing notes that indicated on 9/26/19 staff called to report blood coming from a gash on the top of client #6's head. Further review of nursing documentation revealed the injury to client #6 was unwitnessed by staff and the cause of the injury was unknown. Nursing notes further documented staff were advised to transport client #6 to the emergency room for evaluation. A review of the facility's internal communication log on 11/14/19 verified on 9/26/19 client #6 was taken to the emergency room for a gash to the head. A review of the facility's internal incident reports revealed no report for client #6 on 9/26/19. Review of records for client #6 on 11/14/19 revealed an individual support plan (ISP) dated 11/15/18. Review of the 11/2018 ISP for	W 154	As outlined in the March 18, 2011 memo from CMS regarding Clarification of Reporting Mistreatment, Neglect and Abuse and Injuries of Unknown Source, LIFESPAN will continue to investigate injuries if the source of the injury is unwitnessed by any person, and the injury could not be explained by the client and the injury raises suspicion of possible Abuse, neglect or expolitation. In order to ensure that all incidents are reviewed by administration, the Qualified Professional or Group Home Manager will be responsible for sending all incidents to the Compliance Specialist within 24 hours of completion. The Compliance Specialist will review all incident reports. Injuries of unknown source will specifically be reviewed to see if they involve any suspicion of abuse, neglect or exploitation. If there is reasonable suspicion of abuse, neglect and exploitation, the incident will be investigated by the Compliance department. The Compliance Specialist will send a follow up report to the Qualified Professional and the Senior Director weekly for review of all incidents that are reported.	To be implemented by December 12, 2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Sr. Director of Residential Services — (X6) DATE: 11-26-19

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.

DHSR-Mental Health

DEC 04 2019

Lic. & Cert. Section

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W 154	Continued From page 1 client #6 revealed a behavior support plan for target behaviors of self-injurious behavior, aggression, elopement, inappropriate toileting, PICA, food seeking and destruction of clothing. Interview with the facility home manager (HM) on 11/14/19 verified client #6 has a 1:1 staff due to the severity of behaviors and the need for close supervision. Further interview with the facility HM revealed she did not know why an incident report for client #6 on 9/26/19 was not in the facility's internal book for incident reports. Interview with administration staff on 11/14/19 revealed the incident of unknown origin for client #6 on 9/26/19 resulting in a gash to the client's head requiring external medical evaluation was not reported to administration. Additional interview with administration staff verified an inquiry/investigation should have been conducted relative to the head injury of client #6 on 9/26/19 as details of the injury are unknown and the client has an assigned 1:1 staff.	W 154		
{W 189}	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in completing documentation relative to incident reports in the group home for 6 of 6 clients (#1, #2, #3, #4, #5 and #6.) The finding is:	{W 189}	Staff will receive an in-service ensuring that all injuries are being reported and documented on the incident reporting and injury reporting forms. The Qualified Professional or the Group Home Manager will be responsible for sending all incident reports to the Compliance Specialist within 24 hours of the incident for review. Disciplinary action shall be taken for any staff members who fail to report and incident.	Training will be completed by December 12, 2019. Monitoring and implementation of the new process will be implemented by December 12, 2019 and will be ongoing.

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{W 189}	Continued From page 2 Review of incident reporting for the facility from 1/2019 through 8/2019 revealed no incident reports for 1/2019-5/2019. Incident reports were reviewed for 6/2019, 7/2019 and 8/2019. Interview with QIDP confirmed she was unaware incident reports for the group home were not in the internal record book for incident reports during 1/2019-5/2019. The QIDP subsequently verified incident reports for 1/2019-5/2019 were unavailable for review and it was unknown if staff had completed incident reporting for the months of unavailable reports. A follow up survey was conducted on 11/14/19 for all previous deficiencies cited on 8/20/19. Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in completing documentation relative to incident reports in the group home for 3 of 6 clients (#2, #3 and #6.) The finding is: Review on 11/14/19 of internal documentation relative to the plan of correction for the recertification survey completed on 8/20/19 revealed staff received an in-service training on 9/19/19 conducted by the QIDP titled Incident Reports, proper notification and documentation. A review of incident reports from 9/2019-11/2019 revealed incident reports for clients #2, #3 and #6. Further review of internal incident reports revealed incidents for client #2 on 11/4/19, client #3 on 10/23/19 and client #6 on 9/16/19, 9/18/19, 9/25/19 and 10/24/19. A review of nursing notes on 11/14/19 revealed the following:	{W 189}	Moving forward all incident reports and all levels of incidents need to be scanned and sent to the Compliance Specialist within 24 hours of the incident. Compliance Specialist will review all incidents and follow up with Senior Director weekly to let him know how things are going with these. All staff need to receive the in-service training on incident reporting by December 12, 2019. Derrick will confirm on December 13 that all training's have taken place. Compliance Specialist will discuss with the Qualified Professional and Program Coordinator for LIFESPAN's ICF day services the importance of submitting all incident reports involving ICF individuals to the Group Home administration. The day program Qualified Professional and/or the Program Coordinator will be required to also send all incident reports involving LIFESPAN ICF individuals to the Compliance Specialist. Compliance Specialist will review the incident reports received. Compliance Specialist will meet with the Qualified Professional and Program Coordinator at the day placement and go over the importance of sending all the incident reports home to the group home by December 1, 2019.	Training will be completed by December 12, 2019. Monitoring and implementation of the new process will be implemented by December 12, 2019 and will be ongoing. Training to be conducted by December 1, 2019

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{W 189}	Continued From page 3 On 8/31/19, staff reported client #3 was pushed to the floor by another individual while attempting to walk to the dinner table. Fall unwitnessed. Staff was advised to transport client to urgent care for evalaution. On 9/26/19 staff called to report blood coming from gash on top of scalp. Injury was unwitnessed by staff, cause unknown. Advised to transport to emergency room for evaluation. On 10/11/19 staff called to report client #2 had a fall while attempting to sit down on a shower chair sustaining an abrasion to the lower back. Referred to urgent care for evaluation. On 10/14/19 staff called to report client #3 demonstrating unsteadiness, in need of assistance to stand and a near fall. Advised staff to transport client to urgent care for evaluation. On 10/29/19 staff called to report client #6 to have a quarter sized abrasion to left elbow, advised staff to transport to urgent care for evaluation. Review of the internal communication log on 11/14/19 verified on 9/26/19 client #6 obtained a gash on the head and was taken to the emergency room for evaluation. Interview with the Home Manager (HM) on 11/14/19 confirmed she was unable to locate an incident report form for clients #2, #3 or #6 on 8/31/19. 9/26/19, 10/11/19, 10/14/19 and 10/29/19. Further interview with the HM verified that all client incidents resulting in a referral for extrernal medical evaluation should be	{W 189}		

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{W 189}	Continued From page 4 documented on an incident report form in the facility's incident report book. The HM subsequently verified all incident reports had not been completed by staff as required by the facility for injury/incident reporting.	{W 189}		
{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, review of records and interviews the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 4 of 6 clients. The findings are: A. The facility failed to ensure ambulation guidelines and a communication objective for client #2 were implemented as prescribed. For example: 1. The facility failed to ensure ambulation guidelines for client #2. Observation of client #2 at the vocational program on 8/19/19 at 1:55 PM revealed the client to return from the bathroom to an activity table in the classroom. Client #2 was observed to ambulate	{W 249}	PT guidelines will be developed for client #2 and will be included in his programming. Senior Director of Residential will follow up to ensure that the goal has been written, implemented and is being run correctly and consistently. All staff will be trained by December 10th and Sr. Director will ensure these have been completed by December 11th. The RN will train staff on guidelines by December 10th. The Senior Director of Residential Services will follow up with the group home manager to ensure that the training has been completed by December 11th.	Goals will be implemented by December 9, 2019. Training on goals will be completed by December 10th. Once implemented this will be ongoing. PT training to be conducted by December 10th.

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{W 249}	Continued From page 5 with staff assistance in a wheelchair. Further observation revealed client #2 to transfer from his wheelchair to a chair at the activity table using a two hand supported transition by staff. Staff was observed to stand in front of the client and hold both hands of the client while client #2 ambulated to the chair. Observation during the 8/19-20/19 survey did not reveal client #2 to wear a gait belt. Review of records for client #2 on 8/20/19 revealed an individual habilitation plan (IHP) dated 5/5/19. Review of the IHP revealed a physical therapy (PT) evaluation dated 4/12/19. Review of the PT evaluation revealed a recommendation for an exercise regimen that included: 1) Moving sit to stand 10 times with upper extremity support. 2) Standing with 2 hands support (with walker or caregiver) 15 seconds to 1 minute. 3) Walking progressive distance starting with support from a walker. Contact guard assist from a caregiver is recommended. A gait belt is recommended. A review of internal incident reports on 8/20/19 revealed on 6/26/19 client #2 had a fall while transitioning from a chair at the table to his wheelchair. Further review of the 6/26/19 incident report revealed client #2 to sustain a scrape on his back as a result of the fall. Additional review of records for client #2 revealed no guidelines to support staff with continuity in supporting client #2 with ambulation or transitions. Interview with the facility nurse and qualified intellectual disabilities professional (QIDP) verified client #2 did not have guidelines to support ambulation or transitions. Further interview with the facility nurse and QIDP verified an in-service with staff had not been conducted	{W 249}		

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{W 249}	Continued From page 6 relative to supporting client #2 with ambulation or transitions from his wheelchair. Interview with the QIDP further revealed client #2 had incurred one fall since admission in 4/2019. Subsequent interview with the facility nurse and QIDP verified client #2 did not have a furnished gait belt as recommended for transitions. 2. The facility failed to ensure a communication objective for client #2 was implemented as prescribed. Observations throughout the 8/19-20/2019 survey revealed client #2 to participate in various activities to include an art activity with paint, meal participation, leisure activity (playing checkers with staff, watching television, holding hand held objects such as blocks), medication administration and loading the van for transport. During all observations, client #2 was verbally prompted regarding all transitions. At no time during observations were staff observed to use physical objects to support communication relative to a activity or schedule transition. Review of records for client #2 on 8/20/19 revealed an individual habilitation plan dated 5/5/19. Review of the IHP revealed a communication objective relative to transitions implemented 5/2019. Further review of the communication objective revealed given specific visual prompts paired with objects to hold along with a physical escort to the corresponding area (med cup, toothbrush, spoon), client #2 will transition to specific tasks/activities. Further review of records for client #2 revealed a communication evaluation dated 5/10/19. Review of the 5/2019 communication evaluation revealed the need for programming for client #2 to	{W 249}		

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{W 249}	Continued From page 7 increase receptive and expressive language skills. Interview with the qualified intellectual disabilities professional (QIDP) verified client #2's communication objective relative to transitions remained current and staff should have utilized physical prompts to support the client with transitions. B. The facility failed to ensure ambulation guidelines relative to a gait belt for client #4. For example: Observation of client #4 throughout the 8/19-20/19 survey revealed the client to ambulate with a walker. Observation of client #4 on 8/19/19 at the group home during afternoon observations revealed client #4 to also wear a gait belt underneath his shirt. Observation of client #4 on 8/20/19 in the group home during morning observations revealed the client to wear a gait belt on the outside of his clothing. Continued observations during ambulation of client #4 throughout the 8/19-20/19 survey revealed at various times staff held client #4's gait belt while the client ambulated while at other times staff stood close to client #4 without holding the gait belt. Review of records for client #4 on 8/20/19 revealed an IHP dated 1/29/19. Further record review for client #4 revealed no guidelines to support staff with continuity in supporting client #4 with ambulation. Interview with the facility nurse on 8/20/19 revealed staff should always hold client #4's gait belt during ambulation. The facility nurse further	{W 249}		

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{W 249}	Continued From page 8 verified client #4's gait belt should never be worn under the client's clothing. Subsequent interview with the facility nurse and QIDP verified guidelines specific to the needs of ambulation for client #4 had not been developed and an in-service with staff had not been conducted to address the use of a gait belt for client #4. C. The facility failed to ensure a communication and meal preparation objective for client #3 were implemented as prescribed. For example: 1. The facility failed to ensure a communication objective for client #3 was implemented as prescribed. Observation on 8/19/19 of the dinner meal revealed the place setting for client #3 to include a communication switch. Continued observation of the dinner meal revealed client #3 to participate in and complete the dinner meal and attempt to hit the communication device at his place setting that would not work. Client #3 was observed to hit the communication button multiple times until staff A and the QIDP acknowledged the client and indicated "it's ok, we need to put in a new battery". Observation on 8/20/19 of the breakfast meal revealed the place setting for client #3 to include a communication switch. Continued observation of the breakfast meal revealed client #3 to participate in and complete the breakfast meal and attempt to hit the communication device at his place setting that would not work, and then begin attempting to hit the communication device of another client until staff A intervened and acknowledged client #3.	{W 249}		

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{W 249}	Continued From page 9 Review of records for client #3 on 8/20/19 revealed an IHP dated 3/27/19. Further review of the IHP revealed a communication objective for client #3 to indicate "finished" at snack and meals with a big mack switch implemented 3/2019. Interview with the QIDP on 8/20/19 verified client #3's communication objective relative to using a big mack switch at meals remains current. Further interview with the QIDP verified the communication device was not working at either meal due to the need for a new battery and the battery should have been replaced to allow for client #3 to run his communication program. 2. The facility failed to ensure a meal prepartation objective for client #3 was implemented as prescribed. Observation in the group home on 8/19/19 at 4:45 PM revealed all clients to be engaged in various art and leisure activities. Further observation revealed all dinner items for the dinner meal to be prepared and on the stove with chicken nuggets in the oven. Observation at 5:20 PM revealed staff B to fix all client plates in the kitchen, cut all items to diet size appropriateness for all clients and to serve each client their individual plate at the dining table. Interview with the QIDP at 5:00 PM on 8/19/19 revealed the home manager had prepared all dinner items before clients returned home from their vocational program. Review of records for client #3 on 8/20/19 revealed a IHP dated 3/27/19. Review of the IHP for client #3 revealed a meal preparation objective that client #3 will participate in meal preparation 3 times weekly (Mon, Wed, Fri) with staff assistance, implemented 3/2019.	{W 249}		

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{W 249}	Continued From page 10 Interview with the QIDP confirmed client #3's meal preparation objective remains current and should have been implemented as written on 8/19/19. Further interview with the QIDP revealed she was unsure why the home manager had prepared the dinner meal before all clients had returned home and the meal should not have been prepared until the residents were home. D. The facility failed to ensure a table setting objective for client #1 was implemented as prescribed. For example: Observation in the group home on 8/19/19 at 5:20 PM revealed client #1 to complete an activity at the dining table and to wash his hands for the dinner meal. Further observation revealed client #1 to sit at the dining table until staff served his meal to him from the kitchen at 5:45 PM. Subsequent observation revealed staff A and B to provide each client with cups and their individual plates with dinner items from the kitchen. Observation in the group home on 8/20/19 at 6:20 AM revealed client #1 to sit in the living room with a magazine, to socialize with various staff and survey members and to look at the television until staff A verbally prompted the client to the medication room. Observation at 7:05 AM revealed client #1 to enter the medication room and to exit the medication room to the dining table for breakfast. Client #1 was observed to sit at the dining table until staff C brought serving bowls from the kitchen with breakfast items, at no time was client #1 observed to assist with setting the table for the breakfast meal or prompted by staff to assist with setting the table.	{W 249}		

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{W 249}	Continued From page 11 Review of records for client #1 on 8/20/19 revealed an IHP dated 1/25/19. Review of client #1's IHP revealed a training objective relative to setting the table during meal time implemented 1/2019. Further review of the table setting objective revealed client #1 will participate in setting the table during meal time with staff assistance with no more than 3 verbal prompts. Subsequent review of client #1's IHP revealed with encouragement, client #1 can participate in a wide array of domestic activities around the house. Interview with the QIDP on 8/20/19 revealed client #1's table setting goal remains current and should have been implemented with each meal opportunity. A follow up survey was conducted on 11/14/19: Based on observations, review of records and interviews the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 3 of 6 clients. The findings are: A. The facility failed to ensure a communication objective for client #2 was implemented as prescribed. For example: Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed an in-service would be conducted to address staff utilizing the communication board for client #2. Review of trainings on 11/14/19 revealed no evidence of an in-service training for the communication needs of client #2.	{W 249}	The Qualified Professional will ensure that a communication board will be implemented for client #2. Programming will be established to include goals on the use of the communication board. Sr. Director will confirm that the home has a communication board and if there isn't one there then the QP will develop a communication board by December 10th. Programming will need to be established by the QP and the team to develop goals for the communication board. All staff will be trained on this communication board by December 12th and Sr. Director will confirm that this has been completed on December 13th.	Communication Board and programming to be implemented by December 10, 2019. Training to be completed by December 12, 2019. Sr. Director to confirm by December 13, 2019. This will be ongoing once imlemented.

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	34G184		R 11/14/2019

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{W 249}	Continued From page 12 Interview with the facility home manager (HM) on 11/14/19 verified an in-service was not completed for the communication needs for client #2 relative to the clients communication board. B. The facility failed to ensure ambulation guidelines relative to a gait belt for client #4. For example: During the follow up survey on 11/14/19 observations at the day program from 1:15 PM to 1:30 PM revealed client #4 to transition with staff assistance in the day program with his gait belt underneath his shirt and jacket. Interview with the day program administration staff on 11/14/19 revealed that the facility had not provided training relative to the postion of client #4's gait belt during transition and ambulation support. Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed a program would be created for client #4 to ensure his gait belt is always above his clothing during ambulation assistance. Subsequent review of the record for client #4 revealed an individual habilitation plan (IHP) dated 1/29/19. Continued review of the client record revealed a physical therapy (PT) assessment dated 9/19/19 stating that the gait belt for client #4 should be worn on the outer most layer of his clothing; and gait belt should not be placed over incisions, stitches, tubes, or lines. Further review of internal documentation revealed no evidence of an in-service training of the 9/19/19 ambulation guidelines for staff assisting client #4 in keeping his gait belt above his clothing during ambulation.	{W 249}	Programming will be developed regarding the correct positioning of the gait belt for client #4. Sr. Director of Residential will follow up to ensure that the goal has been written, implemented and is being run correctly and consistently. The Qualified Professional will develop the programming regarding the position of the gait belt. Sr. Director of Residential will meet with QP to develop goal and ensure that the goal starts no later than December 9th. Once developed, the goal will need to be implemented in Therap and staff trained on the goal and processes with the goal. All training with staff will need to be completed by December 10th since data is to be collected starting on this date. Sr. Director of Residential will follow up to ensure that the training has been completed by December 9, 2019. Programming on the Gait Belt will also be shared with the Day Program by December 9, 2019.	Goals will be implemented by December 9, 2019. Training on goals will be completed by December 10th. Once implemented this will be ongoing.

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{W 249}	Continued From page 13 Interview with the facility HM on 11/14/19 verified a program was not implemented for client #4 relative to ensuring his gait belt is worn above clothing during transition and ambulation. Further interview with the HM also confirmed that an in-service training was not completed relative to ambulation guidelines dated 9/19/19 for client #4. C. The facility failed to ensure a communication objective for client #3 was implemented as prescribed. For example: Observations at the group home on 11/14/19 at 8:30 AM revealed a communication device for client #3 to be located in the dining room. Further observation revealed the communication device was not in working order as the device was turned on and pushed by the surveyor. Subsequent observation revealed the HM to change the batteries in the communication device and the device to then work. Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed an in-service would be completed to ensure the communication device for client #3 would function properly for his communication program during meals. The plan of correction further revealed the facility would keep backup batteries in the group home. Continued review of internal documentation revealed no evidence of an in-service relative to the communication device for client #3. Interview with the HM on 11/14/19 verified an in-service was not completed for the communication needs of client #3. Further interview with the HM confirmed the	{W 249}	Sr. Director will work with QP on Mack Switch and putting together in-service for staff. All staff will be trained by December 12th. Sr. Director will confirm all staff are trained by December 13th and review the training attendance sheets. If Sr. Director finds that there are staff who have not been trained he will work with QP to ensure they receive training. Extra batteries for the Mack Switch will be kept in the home at all times. Staff will be trained to check the batteries in the Mack Switch daily. Group Home Manager will be responsible for maintaining the stock of batteries in the home. Sr Director will revise the current weekly checklist to include the supply of batteries and that the Mack Switch is working daily. This checklist is to be submitted to Sr Director every Monday so that he can ensure that all items on checklist are being completed.	Training to be completed by December 12, 2019. Sr. Director to confirm by December 13, 2019. This will be ongoing once imlemented. Extra batteries on home by December 1, 2019. Checklist updated by December 1, 2019. Process will be ongoing.

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{W 249}	Continued From page 14 communication device should be working properly for client #3 to run his communication program during meals.	{W 249}		