PRINTED: 01/21/2020 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			B. WING		R
		MHL026-658	B. WING		01/10/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
CAROL'S	DDA GROUP HOME		ORE STREET EVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on January 10, 2020. This facility is licensed category: 10A NCAC	up survey was completed Deficiencies were cited. d for the following service 27G .5600C Supervised Developmental Disabilities.			
V 114	27G .0207 Emergenc	y Plans and Supplies	V 114		
	AND SUPPLIES (a) A written fire plan area-wide disaster plashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster conshall be held at least repeated for each shirunder conditions that	an shall be developed and the appropriate local made available to all staff dures and routes shall be drills in a 24-hour facility			
	failed to ensure fire an quarterly and repeate are: During interview on 0 revealed the shifts of	ew and interview, the facility and disaster drills were held don each shift. The findings 1/08/2020 the Licensee the facility were:			
	-First shift 7:00am-3:0 -Second shift 3:00pm -Third shift 11:00pm-7	-11:00pm			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
					R	
		MHL026-658	B. WING		01/10/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0.4.001.10		334 MOOR	E STREET			
CAROLS	DDA GROUP HOME	FAYETTEV	ILLE, NC 2830	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	1	V 114			
V 131	January 2019 thru De-No 2nd or 3rd shift f 2019. No 2nd shift fire drill-No 3rd shift disaster 2019. No 3rd shift disaster 2019. No 1st or 3rd shift disaster 2019. No 1st or 3rd shift disaguarter of 2019. During interview on 1. #6 revealed they come at the facility. Interview on 01/08/20. The clients were not due to being in day purity of the disaguarter allowed and the same and the facility had a liven she would ensure allowed and must be corrected. This deficiency constituted and must be corrected. G.S. \$131E-256 (D2) How the same and the same an	/10/2020 clients #2, #4 and apleted fire and disaster drills //20 the Licensee stated: in the facility during the day rograms. e in staff. I the drills were completed y quarter. // duttes a re-cited deficiency d within 30 days. HCPR - Prior Employment ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care and shall note each incident	V 131			

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 2 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7012 1 2701	or connection	A. BUILDING:			
		MHL026-658	B. WING		R 01/10/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CAROL'S	DDA GROUP HOME		RE STREET /ILLE, NC 2830	14	
240.15	CLIMMADY CT		· ·		1 0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 131	Continued From page	e 2	V 131		
V 536	facility failed to docunt Care Personnel Regist of 2 staff (Staff #1). The Review on 01/08/202 revealed: -Hire date 02/20/19The HCPR was not on the Interview on 01/08/202 revealed: -Hire date 02/20/19The HCPR was not on the Interview on 01/08/202 revealed: -Hire date 02/20/19The HCPR was not on the Interview on 01/08/202 revealed: -The HCPR was not on the Interview on 01/08/202 revealed: -The HCPR was not on the Interview on 01/08/202 revealed: -The HCPR was not on the Interview on 01/08/202 revealed: -The HCPR was not on the Interview on 01/08/202 revealed: -The HCPR was not on Interview on 01/08/202 revealed: -The HCPR was not on 10/08/202 revealed: -The HCPR was not on 10/	ews and interviews, the ment accessing the Health stry (HCPR) prior to hiring 1 The findings are: 0 of staff #1's record completed until 03/26/19. 20 the Licensee revealed: e HCPR checks are ch hire. ats - Training on Alt to Rest. TRAINING ON RESTRICTIVE plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in of imminent danger of abuse with disabilities or others or	V 536		

Division of Health Service Regulation

STATE FORM 56899 ZGI111 If continuation sheet 3 of 11

	FICATION NUMBER:	A. BUILDING: _		COMPLETED
MU	L026-658	B. WING		R 01/10/2020
	L020-030			01/10/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CAROL'S DDA GROUP HOME	334 MOORI	E STREET		
	FAYETTEVI	ILLE, NC 2830	01	
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE P TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 536 Continued From page 3		V 536		
based on state competencies, r compliance and demonstrate th gathered. (d) The training shall be compete include measurable learning obmeasurable testing (written and behavior) on those objectives at methods to determine passing course. (e) Formal refresher training my by each service provider period annually). (f) Content of the training that the provider wishes to employ must the Division of MH/DD/SAS pure Paragraph (g) of this Rule. (g) Staff shall demonstrate comfollowing core areas: (1) knowledge and under people being served; (2) recognizing and interpediasibilities; (3) recognizing the effect external stressors that may affed disabilities; (4) strategies for building relationships with persons with (5) recognizing cultural, external stressors that may disabilities; (6) recognizing the importance assisting in the person's involved decisions about their life; (7) skills in assessing indifference and de-escalating potentially datand	tency-based, jectives, I by observation of and measurable or failing the ust be completed ically (minimum he service to be approved by suant to appetence in the standing of the oreting human of internal and act people with tance of and ement in making ividual risk for gies for defusing	V 536		

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 4 of 11

טועוsion d	of Health Service Regu	liation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
				R	
MHL026-658		B. WING		01/10/2020	
		IMI 12020-000			1 01/10/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CAROLIS	DDA GROUP HOME	334 MO	ORE STREET		
CAROL 3	DDA GROOF HOME	FAYETT	EVILLE, NC 2830	01	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				,	
V 536	Continued From page	e 4	V 536		
	means for people with	h disabilities to choose			
	activities which direct				
	behaviors which are				
	(h) Service providers	•			
		ial and refresher training for			
	at least three years.	iai aira reireerier a airiirig rei			
	_	tion shall include:			
		ated in the training and the			
	outcomes (pass/fail);	3			
	(B) when and where they attended; and				
	(C) instructor's name;				
	(2) The Division of MH/DD/SAS may				
		ocumentation at any time.			
	(i) Instructor Qualification	ations and Training			
	Requirements:				
	(1) Trainers sha	all demonstrate competence			
	by scoring 100% on t	esting in a training program			
	aimed at preventing,	reducing and eliminating the			
	need for restrictive in	terventions.			
	` '	all demonstrate competence			
		grade on testing in an			
	instructor training pro	-			
	(3) The training				
	competency-based, include measurable learning				
	objectives, measurable testing (written and by				
	observation of behavior) on those objectives and measurable methods to determine passing or				
		to determine passing or			
	failing the course.	t of the instructor training the			
	(4) The content service provider plans	t of the instructor training the			
		s to employ shall be sion of MH/DD/SAS pursuant			
	to Subparagraph (i)(5				
		instructor training programs			
		not limited to presentation of:			
		ng the adult learner;			
	` '	r teaching content of the			
	course;	. teasining contonic or the			
	,	r evaluating trainee			
	performance: and				

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 5 of 11

	i Health Service Regu		1		 	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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			D WING		F	
		MHL026-658	B. WING		01/1	0/2020
NAME OF D	OVIDED OD CUDDUED	CTDEET ADD	DECC CITY CTA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	ILE, ZIP CODE		
CAROL'S	DDA GROUP HOME	334 MOOR	E STREET			
OAROL O	DDA GROOT HOME	FAYETTEV	ILLE, NC 2830	01		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
V 536	Continued From page	e 5	V 536			
	(D) documentati	ion procedures				
	• ,	ion procedures.				
	` '	all have coached experience				
	teaching a training pro	ogram aimed at preventing,				
	reducing and eliminat	ing the need for restrictive				
	interventions at least	one time, with positive				
	review by the coach.	•				
		all teach a training program				
	` '	reducing and eliminating the				
		-				
		terventions at least once				
	annually.					
	` '	all complete a refresher				
	instructor training at le	east every two years.				
	(j) Service providers	shall maintain				
	documentation of initi	al and refresher instructor				
	training for at least the					
	-	entation shall include:				
		ated in the training and the				
	outcomes (pass/fail);					
	` '	vhere attended; and				
	(C) instructor's					
	(2) The Division	n of MH/DD/SAS may				
	request and review th	is documentation any time.				
	(k) Qualifications of 0	Coaches:				
	• •	all meet all preparation				
	requirements as a tra					
	` '	iall teach at least three times				
	the course which is be	-				
	` '	all demonstrate				
	competence by comp					
	train-the-trainer instru	ıction.				
	(I) Documentation sh	all be the same preparation				
	as for trainers.	,				
			1			

Division of Health Service Regulation

This Rule is not met as evidenced by:

STATE FORM 6899 ZGI111 If continuation sheet 6 of 11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
					R	
		MHL026-658	B. WING		01/10/2020	
NAME OF D	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIR CODE		
NAIVIL OI I	NOVIDEN ON 301 1 EIEN		RE STREET	II.E, ZII GODE		
CAROL'S	DDA GROUP HOME		/ILLE, NC 283(11		
	CUMMADV CT		1		d 0.50	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 536	Continued From page	e 6	V 536			
	Based on interview at failed to ensure an Al Interventions training MH/DD/SAS was con (Staff #1). The finding Review on 01/08/202 revealed: - Hire date was 02/20 - No evidence of an A Intervention training of During interview on 0 -He worked all the times the was unsure of all completed.	and record review the facility ternative to Restrictive approved by the Division of appleted for one of two staff gs are: 0 of staff #1's record 1/19. Internative to Restrictive completed. 1/08/2020 staff #1 revealed: the and was a live in staff.				
	-She would ensure st	aff #1 received the training.				
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to em procedures are retrain competence at least a (b) Prior to providing disabilities whose treat	CAL RESTRAINT AND JT ral restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including				

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 7 of 11

DIVISION	of Health Service Regu	lation			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		B. WING		1		
		MHL026-658	B. W. C		01/10/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
			RE STREET			
CAROL'S	DDA GROUP HOME			24		
		FATELLE	VILLE, NC 2830	J1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	REGULATORT OR I	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NATE	
				, , , , , , , , , , , , , , , , , , ,		
V 537	Continued From page	e 7	V 537			
		plete training in the use of				
	seclusion, physical re	estraint and isolation time-out				
	and shall not use the	se interventions until the				
	training is completed	and competence is				
	demonstrated.					
	(c) A pre-requisite fo	r taking this training is				
		etence by completion of				
		, reducing and eliminating				
	the need for restrictiv					
	(d) The training shall	be competency-based,				
	include measurable le					
		vritten and by observation of				
		pjectives and measurable				
		e passing or failing the				
		e passing or railing the				
	course.	tunimina marrat la a namenlata d				
		training must be completed				
	•	der periodically (minimum				
	annually).					
	(f) Content of the train					
		ploy must be approved by				
	the Division of MH/DI	-				
	Paragraph (g) of this					
		ng programs shall include,				
	but are not limited to,	•				
	\ /	formation on alternatives to				
	the use of restrictive i	,				
	` ,	on when to intervene				
	(understanding immir	nent danger to self and				
	others);					
	(3) emphasis o	n safety and respect for the				
	rights and dignity of a	Ill persons involved (using				
		rictive interventions and				
	incremental steps in a					
		or the safe implementation				
	of restrictive intervent	•				
		emergency safety				
	interventions which in					
		itoring of the physical and				
	psychological well-be	ing of the client and the safe				

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 8 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		D. MINIO		R	
	MHL026-658	B. WING		01/10/2020	_
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
CAROL'S DDA GROUP HOME	334 MOORE	STREET			
CARGE O BBA GROOT TIOME	FAYETTEVI	LLE, NC 2830	91		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	ΓΕ
V 537 Continued From page	8	V 537			
use of restraint through restrictive intervention; (6) prohibited providers and purpos (8) documentation (h) Service providers and commentation of initial at least three years. (1) Documentation (A) who participal outcomes (pass/fail); (B) when and who (C) instructor's received/request this documentation of initial at least three years. (1) Documentation (A) who participal outcomes (pass/fail); (B) when and who (C) instructor's received/request this document (C) instructor Qualificated Requirements: (1) Trainers shall by scoring 100% on tealimed at preventing, reced for restrictive integration (2) Trainers shall by scoring 100% on tealimed at preventing, receding the use of seal and isolation time-out. (3) Trainers shall by scoring a passing goinstructor training proguing competency-based, incobjectives, measurable observation of behavior measurable methods the failing the course. (5) The content of service provider plans	hout the duration of the special content of the duration of the special content of the duration of the special content of the duration of the	V 537			

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 9 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		D 14/11/0		R	
	MHL026-658	B. WING		01/10/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROL'S DDA GROUP HOME	334 MOOF	RE STREET			
CARGEO BBA GROOT HOME	FAYETTE	VILLE, NC 2830	01		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537 Continued From page	9	V 537			
(6) Acceptable shall include, but not of: (A) understandi (B) methods for course; (C) evaluation of (D) documentat (T) Trainers shannually and demonst of seclusion, physical time-out, as specified Rule. (8) Trainers shain teaching the use of least two times with a coach. (10) Trainers shain teaching the use of least two times with a coach. (10) Trainers shain teaching at least two times with a coach. (11) Trainers shain tructor training at least two times with a coach. (11) Trainers shain training for at least the (1) Documentation of inititity training for at least the (1) Documentation (A) who particip outcome (pass/fail); (B) when and vertically outcome (pass/fail); (C) instructor's (D) The Division review/request this documents as a training for coaches shand requirements	instructor training programs be limited to, presentation and the adult learner; reaching content of the of trainee performance; and ion procedures. all be retrained at least strate competence in the use restraint and isolation in Paragraph (a) of this all be currently trained in all have coached experience frestrictive interventions at a positive review by the all teach a program on the eventions at least once all complete a refresher east every two years. It is shall maintain it all and refresher instructor ree years. It is shall include: I in the training and the eventions at least once and in the training and the eventions at least once in of MH/DD/SAS may be comentation at any time. Coaches: I interest all preparation	V 337			

Division of Health Service Regulation

STATE FORM 6899 ZGI111 If continuation sheet 10 of 11

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.	A. BUILDING:		
		MHL026-658	B. WING		01	R / 10/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
CAROL'S	DDA GROUP HOME		RE STREET			
	I		VILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	÷ 10	V 537			
		all demonstrate letion of coaching or ction. hall be the same				
	facility failed to ensure	ews and interviews, the e one of two staff (Staff #1) eclusion, physical restraint				
	revealed: -Hire date was 02/20/ -No documentation of physical restraint and During interview on 0He worked all the timHe was unsure of all	training in seclusion, isolation time-out. 1/08/2020 staff #1 revealed: ue and was a live in staff.				
	revealed:	1/08/2020 the Licensee aff #1 received the training.				

Division of Health Service Regulation

STATE FORM 56899 ZGI111 If continuation sheet 11 of 11