IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
MHL059-070		B. WING		C 04/02/2020	
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INITIAL COMMENT	ГS	V 000			
2020. The complai (#NC00161136). D This facility is licens category: 10A NCA Living for Individual	nt was substantiated beficiencies were cited. sed for the following service AC 27G .5600F Supervised s of all Disability				
	nent/Habilitation Plan	V 112			
TREATMENT/HAB PLAN (c) The plan shall to assessment, and in legally responsible of admission for cline receive services be (d) The plan shall if (1) client outcome(achieved by provisi projected date of ac (2) strategies; (3) staff responsible (4) a schedule for if annually in consultar responsible person (5) basis for evaluar outcome achievem (6) written consent responsible party, consultar responsible party, consulta	ILITATION OR SERVICE be developed based on the in partnership with the client or person or both, within 30 days ents who are expected to syond 30 days. nclude: (s) that are anticipated to be on of the service and a chievement; (e; review of the plan at least ation with the client or legally or both; ation or assessment of ent; and or agreement by the client or or a written statement by the				
	OF CORRECTION PROVIDER OR SUPPLIER MEY HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT A complaint survey 2020. The complaint (#NC00161136). D This facility is license category: 10A NCA Living for Individual Groups-Alternative 27G .0205 (C-D) Assessment/Treatr 10A NCAC 27G .02 TREATMENT/HAB PLAN (c) The plan shall the assessment, and in legally responsible of admission for cliver receive services be (d) The plan shall if (1) client outcome achieved by provisi projected date of act (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evaluar outcome achievem (6) written consent responsible party, consultar provider stating why	OF CORRECTION IDENTIFICATION NUMBER: MHL059-070 PROVIDER OR SUPPLIER STREET A MEY HOME 162 GRE MARION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on April 2, 2020. The complaint was substantiated (#NC00161136). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups-Alternative Family Living. 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL059-070 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S' MEY HOME 162 GREENWOOD DRIMARION, NC 28752 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 A complaint survey was completed on April 2, 2020. The complaint was substantiated (#NC00161136). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups-Alternative Family Living. V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan V 112 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V 112 (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written conse	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL059-070 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MEY HOME 162 GREENWOOD DRIVE MEY HOME 162 GREENWOOD DRIVE SUMMARY STATEMENT OF DEFICIENCIES ID REQULATORY OR LSC IDENTIFYING INFORMATION) PREPIX CEACH DEFICIENCY WAS COMPLETED BY FULL CROSS-REFERENCED TO' INITIAL COMMENTS V 000 A complaint survey was completed on April 2, 2020. The complaint was substantiated (#NC00161136). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups-Alternative Family Living. V 112 27G .0205 (C-D) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V 112 ICA NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V 112 (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedu	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL059-070 B. WING 04/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 162 GREENWOOD DRIVE MEY HOME 162 GREENWOOD DRIVE MARION, NC 28752 SUMMARY STATEMENT OF DEFICIENCY NUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY INITIAL COMMENTS V 000 V 000 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY INITIAL COMMENTS V 000 V 000 A complaint survey was completed on April 2, 2020. The complaint was substantiated (#NC00161136). Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living for Individuals of all Disability Groups-Alternative Family Living. V 112 27G. 0205 (C-D) Assessment/Treatment/Habilitation Plan V 112 10A NCAC 27G. 0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V 112 (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (1) The plan shall include: (1) the plan shall include: (2) staff esponsible; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultati

Division	of Health Service Re	gulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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V 112	Continued From pa	ge 1	V 112			
	failed to develop a t specific strategies a client treatment nee findings are: Record review on 3 -Admitted on 2/7/17 Deficit Disorder, Bi Intellectual Disabilit Willi Syndrome, Op menometrorrhagia, -History of behavior use of profanity, phy seeking behaviors, manipulation. Histo	view and interviews the facility treatment plan which included and interventions to address eds for 1 of 3 clients (#1). The /31/20 for Client #1 revealed: / with diagnoses of Attention Polar Disorder, Mild y, Depression, obesity, Prader positional Defiance Disorder, asthma, and Autism. 's included verbal aggression, ysical aggression, attention self-aggrandizing and prical information also t #1 was prone to make				
	11/12/19 that involv -"[Client #1] told of she could borrow ho went in [Client #1's] wanted to play truth daughters butt. Ou feel uncomfortable daughter tried to lea down on the bed ar and breasts. Our d " Review on 3/31/20 1/1/20 for Client #1 -One goal indicated	of the incident report dated ed Client #1 revealed: our 13 year old daughter that er apple earbuds. When they room [Client #1] said she or dare and touched our r daughter told her it made he and did not want to play. Our ave and [Client #1] pulled her nd was grabbing her crotch aughter managed to escape of the treatment plan dated revealed: I "[Client #1] will have sations and appropriate				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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V 112	Continued From pa	ige 2	V 112				
	included "prompt appropriate conver- using the phonee importance of havin and picturesprais having appropriate -One goal indicated positive appropriate Strategies included interactions with ottl is being inappropriate appropriate relation -No goals or strateg October 2019 incid not address added distance strategies minor in the home -There were no goa plan to address appropriate bounda -There was no goa behaviors that resu expressed by Clien Interview on 3/31/2 #1 revealed: -Client #1 liked to e would send sexual been one incident of another child that of middle school. -There had been no providers about spe only discussion with was "high maintena	gies added to address the ent. The treatment plan did supervision, monitoring or put in place to protect the or around interaction with othe als or strategies added to the propriate touching and aries. I or strategies to address any It from sexual exploration t #1. 0 with the guardian for Client explore sexual things and pictures by phone. There had of a sexual nature that involved occurred when she was in to discussion with the AFL ecifics in Client #1's past. The in the providers was that she	r				

Health Service Re	guiation				
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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Continued From pag	ge 3	V 112			
ninor in the home. lace. Client #1 wa vith any other perso She was very pleas 1 received.	Closer supervision was put in s not allowed to be in a room on. sed with the care that Client				
revealed: -There had always been rules in clients from being in each other the bedrooms of family member daughter being in client bedroor -She was aware that Client #1 h inappropriate behavior on her co line before. She did not know o history. -Following the incident increase monitoring was implemented. -A 3-foot rule was put in place w was around her daughter. Ther no physical contact between he Client #1. -Client #1 saw a behavior speci- recommended behavioral strated behaviors.	been rules in place forbidding n each other's rooms and in nily members and around her ient bedrooms. It Client #1 had engaged in rior on her cell phone and on a not know of any other sexual ent increased supervision and lemented. ut in place whenever Client #1 ighter. There was absolutely between her daughter and havior specialist who avioral strategies to address				
nterviews on 3/30/2 Qualified Profession She confirmed that AFL about clients be and common areas Following the incide nonitoring was imp evisions to the trea	20 and 4/1/20 with the nal revealed: rules were in place at the eing in their own bedrooms only. ent closer supervision and lemented but there were no tment plan. Goals and				
	DF DEFICIENCIES CORRECTION DVIDER OR SUPPLIER EY HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pay round interactions ninor in the home. Iace. Client #1 wa vith any other perso She was very pleas 1 received. There had always b lients from being in the bedrooms of far laughter being in cl She was aware that happropriate behav ne before. She did istory. Following the incide nonitoring was imp A 3-foot rule was p vas around her dau to physical contact Client #1. Client #1 saw a bel ecommended behave the cell phone use troblem was indicat therviews on 3/30/2 Qualified Profession She confirmed that NFL about clients be nonitoring was imp evisions to the treat	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-070 DVIDER OR SUPPLIER STREET AD EY HOME 162 GREE MARION, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 FOOD and the preson. Continued From page 3 FOOD and the person. She was very pleased with the care that Client thereived. There had always been rules in place forbidding lients from being in each other's rooms and in the bedrooms of family members and around her laughter being in client bedrooms. She was aware that Client #1 had engaged in nappropriate behavior on her cell phone and on ne before. She did not know of any other sexual istory. Following the incident increased supervision and nonitoring was implemented. A 3-foot rule was put in place whenever Client #1 vas around her daughter. There was absolutely o physical contact between her daughter and 21/ent #1. Client #1 saw a behavior specialist who ecommended behavioral strategies to address ehaviors. Her cell phone use was monitored and if a roblem was indicated she would address it. netrviews on 3/30/20 and 4/1/20 with the 20/alified Professional revealed: She confirmed that rules were in place at the Following the incident closer supervision and nonitoring was implemented but there were no e	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE PCORRECTION MHL059-070 B. WING MHL059-070 B. WING	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: MHL059-070 B. WING DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EY HOME 162 GREENWOOD DRIVE MARION, NC 28752 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 3 V 112 Continued From page 3 V 112 Continued From page 3 V 112 Sumware person. V 112 She was very pleased with the care that Client th received. V 112 Net revealed: There had always been rules in place forbidding lients from being in each other's rooms and in ne bedrooms of family members and around her laughter being in client bedrooms. She was very thas been rules in place forbidding listory. She was aware that Client #1 had engaged in nappropriate behavior on her cell phone and on ne before. She did not know of any other sexual listory. Following the incident increased supervision and nonitoring was implemented. A3-foot rule was put in place whenever Client #1 ras around her daughter. There was absolutely op physical contact between her daughter and listory. Client #1 saw a behavior specialist who ecommended behavioral strategies to address tenaviors. She confirmed that rules were in place at the FL about clients being in their own bedrooms ind common ar	OPFICIENCIES (x1) PROVIDERSUPPLIER(LIA IDENTIFICATION NUMBER: (x2) MULTPLE CONSTRUCTION A BUILDING: (x3) DATA A BUILDING: DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EY HOME 162 GREENWOOD DRIVE MARION, NC 28752 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTON FAGH OFFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTON CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY WIST BE ADDRESS, CITY, STATE, ZIP CODE Continued From page 3 V 112 Continue Maways been rules in place forbidding lients from being in each other's rooms and in re before. She did not know of any other sexual isfory. Control was put in place A5-fot rule wa

Division	of Health Service Re	aulation			FORM	APPROVED
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V 112	Continued From pa	ge 4	V 112			
	appropriate bounda	ries.				
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	level II incidents, ex the provision of billa consumer is on the incidents and level to whom the provide 90 days prior to the responsible for the services are provide becoming aware of be submitted on a fi Secretary. The rep in person, facsimile means. The report information: (1) reporting identification inform (2) client iden (3) type of ind (4) descriptio (5) status of t cause of the incider (6) other indiv or responding. (b) Category A and missing or incomple shall submit an upd report recipients by day whenever:	JIREMENTS FOR B PROVIDERS B providers shall report all acept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients er rendered any service within incident to the LME catchment area where ed within 72 hours of the incident. The report shall orm provided by the ort may be submitted via mail, or encrypted electronic shall include the following provider contact and ation; tification information; cident; n of incident; he effort to determine the nt; and viduals or authorities notified B providers shall explain any ete information. The provider ated report to all required the end of the next business				
	information provide	er has reason to believe that d in the report may be ing or otherwise unreliable; or				

Division	of Health Service Re	egulation			FORM	APPROVED
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V 367	Continued From pa	ge 5	V 367			
Division of H	required on the inci- unavailable. (c) Category A and upon request by the obtained regarding (1) hospital re- information; (2) reports by (3) the provid (d) Category A and of all level III incider Mental Health, Dev Substance Abuse S becoming aware of providers shall send incidents involving a Health Service Reg becoming aware of client death within s or restraint, the pro- immediately, as req .0300 and 10A NCA (e) Category A and report quarterly to th catchment area who The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (3) searches (4) seizures of the possession of a (5) the total m incidents that occur	umber of level II and level III				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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V 367	Continued From pa	ge 6	V 367			
	incidents have occu meet any of the crit	incidents whenever no urred during the quarter that eria as set forth in Paragraphs Rule and Subparagraphs (1) Paragraph.				
	failed to ensure Lev to the Local Manag	et as evidenced by: view and interview the facility vel III incidents were reported ement Entity (LME) within 72 aware of the incident. The				
	11/12/19 that involv -Incident occurred of documentation was incident. -"[Client #1] told she could borrow h went in [Client #1's] wanted to play truth daughters butt. Ou feel uncomfortable daughter tried to lead down on the bed an	of the incident report dated red Client #1 revealed: on 10/26/19. The s completed as a level 1 our 13 year old daughter that er apple earbuds. When they room [Client #1] said she or dare and touched our ir daughter told her it made her and did not want to play. Our ave and [Client #1] pulled her nd was grabbing her crotch laughter managed to escape				
	(Incident Reporting	of incident reports in IRIS Improvement System) report had been completed for curred on 10/26/19.	r			
	Interview on 4/1/20 Professional reveal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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V 367	Continued From pa	ge 7	V 367			
	level II incident. -The AFL provider v of level 2 incident re which should have	d have been reported as a was responsible for completion eports in their internal system subsequently gone to her for tion of the IRIS report. The level I report.				