STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL092-857	B. WING			2/2020
NAME OF PRO	VIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ANN'S HAVI	EN OF REST II	1919 BOA				
			NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 105 27	7G .0201 (A) (1-7)	Governing Body Policies	V 105			
10 Pro (a fa wi) (1 or (2 (3 (4 (4 (5 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4	OA NCAC 27G .02 OLICIES 1) The governing be cility or service should return policies for the cility of service should return policies for the control of the factorization of service should be control of the factorization of service should be composition, and assessment of the factorization of the factorization of service should be composition and secure and quality assurance and quality and appropriate control of the factorization of service should be composition and secure and quality and appropriate control of the factorization of service should be composition and secure and quality and appropriate factorization of service illigitation of service illigitation of service of the factorization of service of the factor	ody responsible for each call develop and implement the following: anagement authority for the completing assessment; and completing assessment. In agement, including: and to document; ords; cords against loss, tampering, by unauthorized persons; cord accessibility to all times; and confidentiality of records. In the individual's presenting of whether or not the facility is to address the individual's including referrals and the and quality improvement diactivities of a quality continuity improvement committee; and confidentiality of all times; and confidentiality of records. In the individual's including referrals and the and quality improvement diactivities of a quality continuity improvement committee; assurance and quality continuity and evaluating the diateness of client care, and client outcomes and				

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

(X6) DATE TITLE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OI CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		MHL092-857	B. WING	B. WING		; 2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANN'S H	AVEN OF REST II	1919 BOA RALEIGH	Z ROAD , NC 27610			
(X4) ID PREFIX TAG	(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 105	a requirement that sprofessionals and pshall be supervised that area of service (E) strategies for im (F) review of staff qdetermination made treatment/habilitation (G) review of all fatawere being served in residential program (H) adoption of star and programmatic papplicable standard purpose, "applicable means a level of coreference to the premethods, and the distance of the premethods.	staff who are not qualified provide direct client services by a qualified professional in proving client care; ualifications and a to grant	V 105			
	facility failed to ensi	et as evidenced by: views and interviews, the ure an accurate admission clients (#2). The findings are:				
	policy revealed: "Accompleted within 30	of the facility's admission Imission assessment will be days of admission by a nal (QP) or other designated				
	Record review on 8	/28/20 of client #2's				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		MIII 000 055			00/0		
		MHL092-857	B. WING	· · · · · · · · · · · · · · · · · · ·	09/2	2/2020	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ANN'S H	ANN'S HAVEN OF REST II 1919 BO						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
V 105	Continued From pa	ge 2	V 105				
	type -assessment signed Record review on 8	20 coaffective Disorder, Bipolar d by QP /28/20 of a police call service					
	log for client #2 revealed: "On Saturday, May 30, 2020, at approximately 0900 hours (9:00am), I responded to 1919 Boaz Road, in reference to an endangered missing person. The night prior (5/29/20) at approximately 1900 hours, [client #2] was seen walking around the residence. Around that time [client #2] was on his unsupervised time since he currently resides in the group home with [staff#2] as his caretaker. [Client #2]was last seen walking away from the residence and did not return by the time I responded the next day at 0900 hours. [Client #2] was located shortly after at 1016 East Millbrook Road which is his previous group home."						
	-been with the com- -been in this reside	0 with client #2 revealed: pany for almost 3 years nce for about 2-3 months with clients at the previous					
	months after transfer-he (staff #2) recent	0 staff #2 reported: at this facility for a couple of erring from a sister facility tly returned to the facility a ng assigned to a sister facility					
	Interview on 9/16/20 -client #2's admission	0 the QP reported: on date was 6/10/20					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-857	B. WING		09/2	2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANN'S H	AVEN OF REST II	1919 BO				
			, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 105	Continued From pa	ge 3	V 105			
	within 24-48 hours of any porclient #2 in May 202 until 6/10/20  Interview on 8/25/20 officer revealed: -client #2 transferre	Dice coming to the facility for 20 since he was not at facility  O with the Chief Information  d from the sister facility about				
	4-5 months ago (are	ound March/April)				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified in of this Rule shall be enable staff to responeeds.  (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not let the client continues the home or commissive specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders shor of one staff present clients present. Hopresent during slee	in Paragraphs (b), (c) and (d) e determined by the facility to cond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ing in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for itime. The seent in a facility in the fratios when more than one client is present: In a dolescents with substance all be served with a minimum for every five or fewer minor owever, only one staff need be ping hours if specified by the procedures determined by				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-857	B. WING		09/2	2/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ANN'S H	ANN'S HAVEN OF REST II 1919 BC RALEIG					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 290	developmental disa one staff present for present and two star more clients preser need be present duspecified by the endetermined by the endetermi	or adolescents with abilities shall be served with ar every one to three clients aff present for every four or at. However, only one staff uring sleeping hours if aregency back-up procedures governing body. The serve clients whose primary nace abuse dependency: The staff member who is one din alcohol and other drug and symptoms of ations to alcohol and other drug es of a certified substance all be available on an	V 290			
	failed to ensure one plan was reviewed community without periods of time. The Review on 8/25/20 assessment reveals - admitted to the - diagnosis of Sc	view and interview the facility of two clients (#2) treatment as needed to remain in the supervision for specified of findings are:  of client #2's facility's ed: facility on 6/10/20 chizophrenia, Bipolar Type  of a treatment plan dated				
	communitystaff reunsupervised time.	eserves the right to revoke his				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	2. 202011011	.service and the service and t	A. BUILDING:	A. BUILDING:		
		MHL092-857	B. WING		09/2	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
ANN'S H	AVEN OF REST II	1919 BOA RAI FIGH	Z ROAD NC 27610			
(X4) ID PREFIX TAG	(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 290	in the facility and in remainder of the da - updated goal da staff he engaged in something out of a contact his drug corobtain drugs" - "[client #2] co behaviors as he has shopping plaza cen continues to make i comments to femal. The police came to if he is caught up at be arrested. "[Client trespassing and not 7/2/20"  Record review on 8 log for client #2 reve - "On Saturday, Napproximately 0900 to 1919 Boaz Road to an endangered in (5/29/20) at approximately 0900 to 1919 Boaz Road to an endangered in (5/29/20) at approximately in the group home with [Client #2] was seen wall the residence. Around his unsupervised tir in the group home with [Client #2] was lass residence and did in responded the next #2] was located shortly after at 1016 Raleigh, which is his	the community for the ay" ated: 3/22/20 "admitted to drug use this monthsmoked plastic pipehas urges to nect when he has money to nect when he has money to net when he has money to need when he has a court date when he has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor  1/28/20 of a police call service has a court datefor	V 290			

Division of Health Service Regulation

STATE FORM PSVM11 If continuation sheet 6 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		MHL092-857	B. WING		09/2	22/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANN'S H	HAVEN OF REST II	1919 BOA RALEIGH,	Z ROAD , NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 290	- he panhandled - he will walk new go to the store for h - he gives them store chipstells them to  During interview on - client #2 has no due to the pandem - he (client #2) d panhandling  During interview on Officer reported: - client #2 has 8 the community staff encourage due to the pandem - the 8 hours hav - he is his own g - he liked to be in - no police involvadmitted to the faci - client #2 has pac community but not - reasons he has additional hours of cautious & he's mo being out alone  During interview on Professional report - prior to the pan once a week - since the pand zoom - client #2 has a for trespassing at a - he currently ha	for cigarettes not money at door and ask the neighbor to him \$10.00 for cigarettes and keep the change 8/25/20 staff #1 reported: of used his unsupervised time ic oes not have behaviors of 8/25/20 the Chief Information hours unsupervised time in es him not to use all 8 hours ic ye not been reduced uardianhas lived on his own in the community rement since client #2 was lity anhandled while in the since the pandemic is not panhandled: because: peer support; he's more re aware of the danger of 9/16/20 the Qualified ed: demic she visited biweekly or by court date tomorrow (9/17/20)	V 290			

<u> Division</u>	Division of Health Service Regulation							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMPLETED			
					С			
		MHL092-857	B. WING		09/22/2020			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
ANN'S H	AVEN OF REST II	1919 BOA						
		RALEIGH	, NC 27610					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE		
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE		
				DEFICIENCY)				
V 290	Continued From pa	ge 7	V 290					
	<ul><li>he's his own guardian</li><li>client #2 left the facility even we staff asked him to stay</li></ul>							
	- the treatment to	eam has met & the therapist						
		s the 4 hours of unsupervised						
	time	6 333						
	- since he left the asked him to remai	e facility anyway when staff						
		Bpmhe mostly walked to the						
	store and back	opinne mostly wanted to the						
		all clients are being drug						
	tested	3 3						
	- she was not su	re of client #2's drug results						
	but would contact the							
		(QP) Labor day weekend to						
	speak with client #2							
		complained client #2 bothered						
		scaping, mow lawn, etc.) tarted this week seeking a						
		#2, he has a 1:1 peer, attends						
	NA/AA meetings on							
	· ·							
		ne calls were made to staff #2:						
		no return calls by close of						
	survey							
	During interview on	9/22/20 the Chief Information						
	Officer reported:	GIZZIZO ING OTHER IIIIOITHAUOH						
		n an outing with staff						
	- he went missing							
	- staff contacted							
		all when the incident						
	happened							
		her of the incident on Friday						
	(9/18/20)	nave contacted the nation						
	since he has unsup	nave contacted the police						
		s were faxed for client #2, she						
	will refax	Word land for olient #2, sile						
		ere not received by exit date						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	0. 0020		A. BUILDING:			
	MHL092-857		B. WING		09/2	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
A NINI'C LI	AVEN OF BEST II	1919 BOA	Z ROAD			
AININ 5 II	AVEN OF REST II	RALEIGH	, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 290	Continued From pa	ae 8	V 290			
	•	3				
	(9/22/20)					
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	10A NCAC 27G .06					
	REPORTING REQ					
		B providers shall report all				
	level II incidents, ex	cept deaths, that occur during				
	the provision of billable 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				
	information:	enan merade are renerming				
	(1) reporting	provider contact and				
	identification inform	•				
		ntification information;				
	<ul><li>(3) type of ind</li><li>(4) descriptio</li></ul>	cident; n of incident;				
		the effort to determine the				
	cause of the incide					
		viduals or authorities notified				
	or responding.					
		B providers shall explain any				
		ete information. The provider				
		lated report to all required the end of the next business				
	day whenever:	the end of the next publicess				
		ler has reason to believe that				
		d in the report may be				
		ing or otherwise unreliable; or				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED	
					_	`
		MHL092-857	B. WING		09/2	2/2020
					03/2	ZIZUZU
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANN'S H	AVEN OF REST II	1919 BOA	_			
	ı	RALEIGH	, NC 27610			
(X4) ID	-	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 367	Continued From pa	ge 9	V 367			
		ler obtains information dent form that was previously				
	unavailable.	dentiform that was previously				
		B providers shall submit,				
		E LME, other information				
		the incident, including:				
	(1) hospital re	ecords including confidential				
	information;					
		other authorities; and				
		ler's response to the incident.				
		B providers shall send a copy				
		nt reports to the Division of elopmental Disabilities and				
		Services within 72 hours of				
		the incident. Category A				
		d a copy of all level III				
		a client death to the Division of				
		ulation within 72 hours of				
		the incident. In cases of				
		seven days of use of seclusion				
		vider shall report the death				
		uired by 10A NCAC 26C AC 27E .0104(e)(18).				
		B providers shall send a				
		he LME responsible for the				
		ere services are provided.				
		submitted on a form provided				
	by the Secretary via	a electronic means and shall				
		formation as follows:				
		n errors that do not meet the				
		II or level III incident;				
	\ <i>\</i>	interventions that do not meet				
		evel II or level III incident; of a client or his living area;				
		of a client property or property in				
	the possession of a					
		number of level II and level III				
	incidents that occur					
		ent indicating that there have				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL092-857	B. WING		09/2	22/2020
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ANN'S H	AVEN OF REST II	1919 BOA RALEIGH,	NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( 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	(X5) COMPLETE DATE
V 367	been no reportable incidents have occumeet any of the crit (a) and (d) of this R through (4) of this R	incidents whenever no urred during the quarter that eria as set forth in Paragraphs (1) Paragraph.	V 367			
	facility failed to ens were submitted to to Organization/Local (MCO/LME) within Review on 8/19/20 Improvement Syste - no level II incident the system since N	ure level II incident reports he Managed Care Management Entity 72 hours. The findings are: of the Incident Response em (IRIS) revealed: t reports have been entered in				
	log for client #2 rev "On Saturday, May 0900 hours (9:00ar Road, in reference to an endangered r (5/29/20) at approx #2] was seen wal the residence. Arouhis unsupervised tilin the group home wit [Client #2]was las residence and did r	ealed: 30, 2020, at approximately n), I responded to 1919 Boaz nissing person. The night prior imately 1900 hours, [client				

Division of Health Service Regulation

STATE FORM PSVM11 If continuation sheet 11 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-857	B. WING			C <b>22/2020</b>
	NAME OF PROVIDER OR SUPPLIER  ANN'S HAVEN OF REST II  RALEIGH  RALEIGH			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 367	#2] was located shortly after at 1016 Raleigh, which is hi Interview 9/16/20 w revealed: -no Level II reports -no knowledge of all report -staff is to notify QP clients -unaware of police missing person in M Interview 8/25/20 w revealed: -no police calls or in several months -unaware of any receno IRIS reports had During interview on Officer reported: - client #2 was on he went missing - staff contacted - she doesn't receno happened - the QP notified (9/18/20) - an incident reports	6 East Millbrook Road, s previous group home."  ith Qualified Professional (QP)  ny incidents requiring a Level  of all incidents involving  being called to the facility for a May 2020  ith Chief Information officer  nvolvement within the last  cent incidents at the home we been submitted  9/22/20 the Chief Information  n an outing with staff g for 3 hours the police all when the incident  her of the incident on Friday  orted was not completed have contacted the police	V 367			

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