	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETEL	
		MIII 004 440	B WING		R	004
		MHL081-112			06/07/20	021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
PEACE IN	THE CITY HOUSE OF H	OPE	CASTLE LANE CITY, NC 28043	3		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
		d for the following service 27G .1700 Residential re for Children or				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications are corded immediately MAR is to include the (A) client's name; (B) name, strength, and (C) instructions for according the corder of	istration: n-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. clinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:				

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

(X6) DATE TITLE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	J. CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COWFLETED	
		MHL081-112	B. WING		R 06/07/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DEACE IN	THE CITY HOUSE OF U	265 OLD C	ASTLE LANE			
PEACE IN	THE CITY HOUSE OF H	FOREST C	ITY, NC 28043	3		
(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 APPROPE DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	<u>.</u> 1	V 118			
	checks shall be recor	ded and kept with the MAR pointment or consultation				
	interviews, the facility medications as ordered	ews, observation, and failed to administer ed by an authorized person o to date affecting 1 of 3				
	Attention Deficit-Hyper-Age: 17 - Physicians orders for 1. Cetirizine 10 mg (no (every morning), date 2. Trazodone 50mg, adated 4/14/2021; 3. Fluticasone Prop 5 spray, use 1 spray in dated 8/20/2020; 4. ProAir HFA (Albute puffs Q4 (every four)	A/2020 aumatic Stress Disorder; and eractivity Disorder (ADHD). or the following medications: nilligrams), 1 tablet QAM ed 8/20/2020; 1 tablet QHS (at bedtime), 0 mcg (micrograms) nasal each nostril QD (every day), erol) 90mcg inhaler, inhale 2 hours, dated 8/20/2020, with ouffs Q4 hours QD PRN (as				
	MARs dated 3/1/2021 - The administration in	& 6/3/2021 of client #2's I to 6/2/2021 revealed: Instructions on the MARs for I and fluticasone prop listed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
			D MINO			₹
		MHL081-112	B. WING		06/0	07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PEACE IN	THE CITY HOUSE OF H	OPE 265 OLD	CASTLE LANE			
I LAGE III		FOREST	CITY, NC 28043			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	2	V 118			
	each medication as a medication as ordere - Cetirizine, Trazodon documented as havin every day Administration instruwere: inhale 2 puffs of from 3/1/2021 to 4/2/2 - The ProAir inhaler wheen administered or hours from 3/1/2021 to 4/2/2021 of client #2's - Cetirizine 10mg, tak 4/24/2021 and 5/25/2 - Trazodone 50mg, tainsomnia, filled on 4/2 - Fluticasone prop na each nostril QD, filled	PRN rather than routine d. de, fluticasone prop were g been administered once uctions for the ProAir inhaler QD PRN bronchospasm, 2021. Vas documented as having nee daily rather than every 4 to 4/14/2021. Eximately 9:40pm on as medications revealed: e one tablet QD, filled on 021. Rike 1 tablet QHS PRN 23/2021. sal spray, use 1 spray in				
	- He took medications could not recall their in the thought that he is medications correctly Interview on 6/3/2021 Manager (AHM) reversely - Client #2's cetirizing medication Client #2 had always once daily, and neversely - He thought that Client administered his medication in the was responsible administration instruction.	with the Assistant House aled: had never been a PRN s used the ProAir inhaler every 4 hours. nt #2 had been lications correctly. for entering medication				

Division of Health Service Regulation

STATE FORM 8899 29DU11 If continuation sheet 3 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
					R
		MHL081-112	B. WING		06/07/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DEACE IN	THE CITY HOUSE OF H	265 OLD	CASTLE LANE		
PEACE IN	THE CITY HOUSE OF H	FOREST	CITY, NC 28043	3	
(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)	JLD BE COMPLETE
V 118	Continued From page	÷ 3	V 118		
	from the previous mobeen an order change - Facility clients did not often Since there had not client #2's medication error indicating the mMAR He would ensure the corrected immediately	been any order changes to us, he had not caught the edications were PRN on the e errors on the MARs were			
	Interview on 6/3/2021 with the Associate Professional (AP) revealed: - The AHM was the primary staff responsible for oversight of MARs She assisted the AHM when there were issues related to authorizations for medications She thought that Client #2 had been administered his medications correctly every day.				
		re Director revealed: e that provides the ation training to staff ccuracy.			
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131		
	REGISTRY (d2) Before hiring hea health care facility or	ALTH CARE PERSONNEL Alth care personnel into a service, every employer at a all access the Health Care			

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STATE FORM 8899 29DU11 If continuation sheet 4 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL081-112	B. WING		R 06/07/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	1 00.01.72021
PEACE IN	THE CITY HOUSE OF H	OPE	CASTLE LANE CITY, NC 28043		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
V 131		nd shall note each incident	V 131		
	failed to access the H	ew and interview, the facility lealth Care Personnel r to hire affecting 1 of 3			
	Review on 6/3/2021 of revealed: - Hire date: 1/20/2019 - Documentation that accessed until 1/30/2	the HCPR was not			
	related to accessing t - The Chief Executive working on getting all background checks c	re Director revealed: een cited for a deficiency he HCPR in the past. e Officer (CEO) had been			
V 133	G.S. §122C-80 CRIM CHECK REQUIRED APPLICANTS FOR E (a) Definition As us		V 133		
		vider of mental health,			

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STATE FORM 8899 29DU11 If continuation sheet 5 of 11

Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					F	,
		MHL081-112	B. WING		1	7/2021
					,	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PEACE IN	THE CITY HOUSE OF H	OPE	CASTLE LANE			
		FOREST	CITY, NC 28043	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
1710		,	,,,,,	DEFICIENCY)		
V 133	Cantinual Francisco	. 5	V 133			
V 133	Continued From page	5 5	V 133			
	developmental disabil	lity, and substance abuse				
	services that is licens	able under Article 2 of this				
	Chapter.					
		offer of employment by a				
	provider licensed und					
		ion that does not require the				
		occupational license is				
		nt to a State and national				
	_	d check of the applicant. If				
		n a resident of this State for				
		hen the offer of employment				
		sent to a State and national				
	national criminal histo	d check of the applicant. The				
		e applicant's fingerprints. If				
		n a resident of this State for				
		en the offer is conditioned				
	_	criminal history record				
	check of the applicant	•				
		vho refuses to consent to a				
		d check required by this				
		nerwise provided in this				
		business days of making				
		f employment, a provider				
	shall submit a reques	t to the Department of				
	Justice under G.S. 11	4-19.10 to conduct a				
	criminal history record	d check required by this				
		it a request to a private				
	-	ate criminal history record				
		s section. Notwithstanding				
		epartment of Justice shall				
		ational criminal history				
		ployment positions not				
	covered by Public Lav					
	Department of Health	and Human Services,				

Division of Health Service Regulation

Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check

STATE FORM 8899 29DU11 If continuation sheet 6 of 11

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL081-112	B. WING		06/07/2021
					1 00.01.2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
PEACE IN	THE CITY HOUSE OF H	OPE	CASTLE LANE		
		FOREST	CITY, NC 28043	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
1710		,	,,,,,	DEFICIENCY)	
1/ 122	O	. 0	V 133		
V 133	Continued From page	9 0	V 133		
	Unit, shall notify the p	rovider as to whether the			
	information received i	may affect the employability			
	of the applicant. In no	case shall the results of the			
	national criminal histo	ry record check be shared			
	with the provider. Pro	viders shall make available			
	upon request verificat	tion that a criminal history			
	check has been comp	oleted on any staff covered			
		nty that has adopted an			
		nance and has access to			
		al Information data bank			
		ılf of a provider a State			
	-	d check required by this			
	-	ovider having to submit a			
		ment of Justice. In such a			
	_	I commence with the State			
		d check required by this			
	section within five bus				
		nployment by the provider.			
		ormation received by the			
	•	al and may not be disclosed,			
		nt as provided in subsection			
	(c) of this section. For	purposes of this private entity" means a			
	business regularly en				
		d checks utilizing public			
	records obtained from				
		licant's criminal history			
	* *	one or more convictions of			
		e provider shall consider all			
		s in determining whether to			
	hire the applicant:	3			
	(1) The level and seri	ousness of the crime.			
	(2) The date of the cri				
		rson at the time of the			
	conviction.				
	(4) The circumstance	s surrounding the			
	commission of the cri				
	(5) The nexus between	en the criminal conduct of			
	the person and the jo	b duties of the position to be			

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	i Health Service Negu	iauon	1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MUU 004 440	B. WING			
		MHL081-112			06/07	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		265 OLD (CASTLE LANE			
PEACE IN	THE CITY HOUSE OF H	OPE	CITY, NC 28043			
			7111, 110 20040			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
1/ 400		_	1// 400			
V 133	Continued From page	2.7	V 133			
	filled.					
	(6) The prison, jail, pr	obation, parole.				
		ployment records of the				
		the crime was committed.				
	•	ommission by the person of				
	a relevant offense.	ommodern by the percent of				
		of a relevant offense alone				
		employment; however, the				
		considered by the provider.				
		ifies an applicant after				
	· · · · · · · · · · · · · · · · · · ·	elevant factors, then the				
		e information contained in				
		cord check that is relevant				
		but may not provide a copy				
	of the criminal history	record check to the				
	applicant.	A				
		- A provider and an officer				
		vider that, in good faith,				
		ction shall be immune from				
	civil liability for:					
	(1) The failure of the					
		s of information provided in				
		cord check of the individual.				
	• •	n employee's history of				
	criminal offenses if the					
		s requested and received in				
	compliance with this s					
	• ,	- As used in this section,				
		ans a county, state, or				
		y of conviction or pending				
		whether a misdemeanor or				
		n an individual's fitness to				
		the safety and well-being of				
		ital health, developmental				
	disabilities, or substan	nce abuse services. These				
	crimes include the cri	minal offenses set forth in				
	any of the following A	rticles of Chapter 14 of the				
		cle 5, Counterfeiting and				
	Issuing Monetary Sub					

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL081-112	B. WING		R 06/07/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	
			CASTLE LANE	,	
PEACE IN	THE CITY HOUSE OF H	OPE	CITY, NC 28043	3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG		,	IAG	DEFICIENCY)	
V 133	Continued From page	÷ 8	V 133		
	Endangering Executiv	e and Legislative Officers;			
	Article 6, Homicide; A	rticle 7A, Rape and Other			
		8, Assaults; Article 10,			
		ction; Article 13, Malicious			
	Injury or Damage by I				
		Material; Article 14, Burglary kings; Article 15, Arson and			
		e 16, Larceny; Article 17,			
		Embezzlement; Article 19,			
	False Pretenses and				
	Obtaining Property or				
	Fraudulent Use of Cre	edit Device or Other Means;			
		Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against				
	•	Adult Establishments;			
		n; Article 28, Perjury; Article , Misconduct in Public			
	•	enses Against the Public			
		iots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam				
		le 60, Computer-Related			
	Crime. These crimes	also include possession or			
	~	ion of the North Carolina			
		s Act, Article 5 of Chapter			
		tutes, and alcohol-related			
		to underage persons in			
	violation of G.S. 18B-				
	G.S. 20-138.5.	of G.S. 20-138.1 through			
		ing False Information Any			
	•	nent who willfully furnishes,			
		gives false information on			
		cation that is the basis for a			
		d check under this section			
	shall be guilty of a Cla	ass A1 misdemeanor.			

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(g) Conditional Employment. - A provider may employ an applicant conditionally prior to

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
			A. BOILDING.			В
		MHL081-112	B. WING		06	R 5/ 07/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		265 OLD	CASTLE LANE			
PEACE IN	I THE CITY HOUSE OF H	OPE FOREST	CITY, NC 28043			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 133	obtaining the results of check regarding the a following requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employment 2001-155, s. 1; 2004-	of a criminal history record applicant if both of the its are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five the individual begins	V 133			
	failed to request a cri check within 5 days of offer of employment at (#2). The findings are Review on 6/3/2021 of revealed: - Hire date: 1/20/2015 - Documentation that check was not request Interview on 6/7/2021 Professional/Executive - The Licensee had be related to requesting check in the past.	ew and interview, the facility minal history background of making the conditional affecting 1 of 3 audited staff e: of staff #2's employee record the criminal history record sted until 2/6/2019.				

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Division of Health Service Regulation

MANUE OF PROVIDER OR SUPPLIER PEACE IN THE CITY HOUSE OF HOPE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE COMPRISE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE COMPRISE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE COMPRISE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE COMPRISE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TANK THE CITY HOUSE OF HOPE COMPRISE (EACH DEPICIENCY MUST SEE PRECEDED BY PULL TO SHOULD BE COMPRISE OF HOPE COM		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER PEACE IN THE CITY HOUSE OF HOPE 265 OLD CASTLE LANE FOREST CITY, NC 28043 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY V 133 Continued From page 10 background checks completed in the required time frames since the last time the Licensee was			MHL081-112	B. WING		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 133 Continued From page 10 background checks completed in the required time frames since the last time the Licensee was	NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 133 Continued From page 10 background checks completed in the required time frames since the last time the Licensee was	PEACE IN	THE CITY HOUSE OF H	OPF		3	
background checks completed in the required time frames since the last time the Licensee was	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE COMPLETE
	V 133	background checks co	ompleted in the required	V 133		

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