Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL049-116	B. WING		12/17/2021	
NAME OF PI	ROVIDER OR SUPPLIER	303 SAINT	ANDREWS RO	DAD		
		STATESVII	LLE, NC 2862	5		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPL	LETE
V 000	INITIAL COMMENTS		V 000			
	Deficiencies were cite					
	category: 10A NCAC	d for the following service 27G .5100 Community ndividuals of All Disability				
	The survey sample cocurrent clients.	onsisted of audits of 2				
V 536	27E .0107 Client Righ Int.	nts - Training on Alt to Rest.	V 536	V 536 / V 537 RCD completed Alternatives to Restrictive Intervention training on 12/28/21 and 12/2	9/21.	
	10A NCAC 27E .0107 ALTERNATIVES TO F INTERVENTIONS	RESTRICTIVE		Meaures put in place: -Future employees will not be permitted to Resource Center until Alternative to Resti Intervention training is completed.		
	to restrictive intervent	size the use of alternatives		Who will monitor: -Lead Counselor, RCD, Assistant Director will montior monthly to ensure compliance		
	disabilities, staff include employees, students demonstrate compete	ding service providers, or volunteers, shall ence by successfully		V 536 / V 537 Staff #1 completed their annual recertifical Training in physical restraint on Tuesday, July 13, 2021.	ion	
	other strategies for crewhich the likelihood or or injury to a person w	communication skills and eating an environment in f imminent danger of abuse vith disabilities or others or		Measures put in place: -Future employees will not be permitted to Resource Center until annual recertification is completed.		
	based on state compe	s shall establish training etencies, monitor for internal		Who will monitor: -Lead Counselor, RCD, Assistant Director will monitor monthly to ensure compliance		
	gathered.	onstrate they acted on data				
	include measurable le measurable testing (w	earning objectives, vritten and by observation of				
	behavior) on those ob methods to determine course.	jectives and measurable passing or failing the				

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

## Michelle Kluttz, RHA State START Director

12/20/21

(X6) DATE

STATE FORM 6899 If continuation sheet 1 of 11 Z94T11

Division of Health Service Regulation

DIVISION	n Health Service Negu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MUU 040 446	B. WING		40/47/0004	
		MHL049-116	1		12/17/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		303 SAINT	ANDREWS RO	DAD		
CHESTNU	T GROVE	STATESVI	LLE, NC 2862	5		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
V 536	Continued From page	<u>.</u> 1	V 536			
	. •					
	• ,	training must be completed				
	•	der periodically (minimum				
	annually).					
	(f) Content of the trai					
	•	nploy must be approved by				
	the Division of MH/DE	•				
	Paragraph (g) of this					
	(0)	strate competence in the				
	following core areas:					
	(1) knowledge	and understanding of the				
	people being served;					
	(2) recognizing	and interpreting human				
	behavior;					
	` ,	the effect of internal and				
		it may affect people with				
	disabilities;					
		or building positive				
	relationships with per-					
	` ,	cultural, environmental and				
	organizational factors	that may affect people with				
	disabilities;					
	(6) recognizing	the importance of and				
	assisting in the perso	n's involvement in making				
	decisions about their	life;				
	(7) skills in asse	essing individual risk for				
	escalating behavior;					
	(8) communication	tion strategies for defusing				
	and de-escalating pot	tentially dangerous behavior;				
	and					
	(9) positive beh	navioral supports (providing				
		n disabilities to choose				
	activities which direct	ly oppose or replace				
	behaviors which are u					
	(h) Service providers	shall maintain				
	documentation of initi	al and refresher training for				
	at least three years.	-				
		tion shall include:				
		ated in the training and the				
	outcomes (pass/fail);	č				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 2 of 11

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING			
		MHL049-116	B. WING		12/17/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
			ANDREWS RO			
CHESTNU	T GROVE					
		SIAIESVI	LLE, NC 28625			
(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 APPROPR		
TAG	REGULATORT OR I	LOC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	IATE DATE	
			1	,		
V 536	Continued From page	2	V 536			
	(D)ban and					
		where they attended; and				
	(C) instructor's					
	• ,	n 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 to	esting in a training program				
	aimed at preventing,	reducing and eliminating the				
	need for restrictive inf	terventions.				
	(2) Trainers sha	all demonstrate competence				
	by scoring a passing	grade on testing in an				
	instructor training pro	gram.				
	(3) The training	shall be				
	competency-based, ir	nclude measurable learning				
		le testing (written and by				
	•	ior) on those objectives and				
		to determine passing or				
	failing the course.	1 3				
	_	t of the instructor training the				
	service provider plans	· ·				
		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				
	` '	r teaching content of the				
	course; (C) methods fo	r evaluating trainee				
	performance; and	i Cvaluating trainice				
	•	ion procedures.				
		all have coached experience				
		ogram aimed at preventing,				
		ting the need for restrictive				
		one time, with positive				
	review by the coach.					
		all teach a training program				
		reducing and eliminating the				
	need for restrictive int	terventions at least once				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 3 of 11

Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL049-116	B. WING		12/1	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
CHESTNU	T GROVE		TANDREWS RO			
(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	(X5) COMPLETE DATE
V 536	instructor training at le (j) Service providers documentation of initi training for at least the (1) Docume (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division request and review th (k) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh the course which is be (3) Coaches sh competence by comp train-the-trainer instru	all complete a refresher east every two years. shall maintain ial and refresher instructor ree years. entation shall include: eated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation hiner. hall teach at least three times eing coached. hall demonstrate bletion of coaching or	V 536			
	facility failed to ensur- alternatives to restrict providing services aff (the Resource Center to ensure formal refre	ew and interviews, the e staff completed training on tive interventions prior to fecting 1 of 3 audited staff r Director (RCD)); and failed esher training was completed cting 1 of 3 audited staff				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 4 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL049-116	B. WING		12/17/2021	
NAME OF PROVIDE	ER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
CHESTNUT GR	OVE		T ANDREWS RO			
			ILLE, NC 2862	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 536 Con	tinued From page	4	V 536			
reco - Hir - Do restr - Re 7/13  Rev RCE - Hir - Do restr 6/9/2 - No to re Inter - Sh alter know refre  Inter - Sh train curri - Th beer train Inter - Tra inter RCE clas - 4 c	ord revealed: re date: 2/24/2020 recumentation that rictive intervention of the straining with the strictive intervention of the strictive intervention.  The strictive intervention of the strictive intervention of the strictive intervention.  The strictive intervention of the strictive intervention of the strictive intervention of the strictive intervention of the strictive interventions was laterated of the strainers in the striction of the strainers in the strainer	training on alternatives to s had expired on 3/3/2021. as not completed until  21 & 12/17/2021 of the rd revealed:  training on alternatives to s was not begun until  at training on alternatives ons was fully completed.  21 with Staff #1 revealed: ve attended the training on ve interventions, but did not a so long for her to get the  21 with the RCD revealed: e first part of the facility's so to restrictive interventions t yet attended the final part. ess Manager (HRM) had onsible for scheduling her so hired.				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 5 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING	A. BUILDING.	
		MHL049-116	B. WING		12/17/2021
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHESTNUT (	GROVE	303 SAIN	T ANDREWS RO	DAD	
		STATESV	ILLE, NC 28625		
(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 APPROI DEFICIENCY)	D BE COMPLETE
V 536	Continued From page	5	V 536		
tr	aining on alternative	d taking the first part of the sto restrictive interventions mpleted the final part.			
	7E .0108 Client Righ ΓΟ	ts - Training in Sec Rest &	V 537		
Sisting (a titing by control of the	SOLATION TIME-OUT  a) Seclusion, physical me-out may be emplored and have competence in the pro- to these procedures.  It aff authorized to emit of the procedures are retrained at least at a competence providers, emploited and shall not use these arising is completed at emonstrated.  C) A pre-requisite for emonstrating competence at least at a competence at least at a competence and shall not use these arising is completed at emonstrated.  C) A pre-requisite for emonstrating competence arising in preventing, and need for restrictive and the training shall be a competence and the process of the	CAL RESTRAINT AND T all restraint and isolation oyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that ploy and terminate these ned and have demonstrated innually. direct care to people with itment/habilitation plan reventions, staff including ployees, students or lete training in the use of straint and isolation time-out re interventions until the and competence is  taking this training is tence by completion of reducing and eliminating e interventions. De competency-based,			

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 6 of 11

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		MHL049-116	B. WING		12/17/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CHECTNI	IT CDOVE	303 SAII	NT ANDREWS RO	DAD	
CHESTNO	IT GROVE	STATES	VILLE, NC 28625	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 6	V 537		
	the Division of MH/DE Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher into the use of restrictive in (2) guidelines of (understanding imminothers); (3) emphasis or rights and dignity of a concepts of least rest incremental steps in a (4) strategies for of restrictive intervent (5) the use of einterventions which in assessment and mon psychological well-be use of restrictive interventions (6) prohibited prohibite	ploy must be approved by D/SAS pursuant to Rule. Ing programs shall include, presentation of: formation on alternatives to interventions; on when to intervene tent danger to self and in safety and respect for the ll persons involved (using rictive interventions and an intervention); or the safe implementation ions; mergency safety clude continuous itoring of the physical and ing of the client and the safe ghout the duration of the in; rocedures; trategies, including their iose; and ion methods/procedures. shall maintain all and refresher training for the training and the include: atted in the training and the information at any time.			

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 7 of 11

Division of Health Service Regulation

DIVISION	n Health Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
		MUU 040 440	B. WING		40/47/	10004
		MHL049-116	5:		12/17/	2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		303 SAIN	T ANDREWS RO	DAD		
CHESTNU	T GROVE		ILLE, NC 28625			
	CLIMMA DV CT				- N	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
V 537	Continued From none	- 7	V 537			
V 331	Continued From page	e /	V 557			
	Requirements:					
	(1) Trainers sha	all demonstrate competence				
	by scoring 100% on to	esting in a training program				
		reducing and eliminating the				
	need for restrictive int					
	(2) Trainers sha	all demonstrate competence				
		esting in a training program				
	-	eclusion, physical restraint				
	and isolation time-out					
		 all demonstrate competence				
	` '	grade on testing in an				
	instructor training pro	-				
	(4) The training	_				
	` ,	nclude measurable learning				
		le testing (written and by				
	-	- ,				
		for) on those objectives and				
		to determine passing or				
	failing the course.					
	• ,	t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6					
		instructor training programs				
	•	be limited to, presentation				
	of:					
		ng the adult learner;				
	` '	r teaching content of the				
	course;					
	, ,	of trainee performance; and				
	• •	ion procedures.				
	\ <i>\</i>	all be retrained at least				
		trate competence in the use				
		restraint and isolation				
	time-out, as specified Rule.	in Paragraph (a) of this				
	(8) Trainers sha	all be currently trained in				
	CPR.					
		all have coached experience frestrictive interventions at				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 8 of 11

Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			7 20.22 10.			
		MHL049-116	B. WING		12/1	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ALE, ZIP CODE		
CHESTNU	IT GPOVE	303 SAIN	T ANDREWS R	DAD		
CHESTING	I GROVE	STATES\	ILLE, NC 2862	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
\/ 507	0 :	•	V/ 507			
V 537	Continued From page	e 8	V 537			
	least two times with a	a positive review by the				
	coach.	a positive review by the				
		-11 4				
		all teach a program on the				
		rventions at least once				
	annually.					
	(11) Trainers sha	all complete a refresher				
	instructor training at le	east every two years.				
	(k) Service providers	shall maintain				
	•	ial and refresher instructor				
	training for at least th	ree vears.				
	_	tion shall include:				
		ated in the training and the				
		ated in the training and the				
	outcome (pass/fail);					
		vhere they attended; and				
	(C) instructor's					
	(2) The Division	n of MH/DD/SAS may				
	review/request this do	ocumentation at any time.				
	(I) Qualifications of C	Coaches:				
	(1) Coaches sh	nall meet all preparation				
	requirements as a tra					
	•	nall teach at least three				
	times, the course whi					
		nall demonstrate				
	` '					
	competence by comp	_				
	train-the-trainer instru					
	(m) Documentation s					
	preparation as for train	iners.				
	This Rule is not met	as evidenced by:				
		ew and interviews, the				
		•				
	_	e staff completed training in				
		estraint and isolation time out				
	prior to providing serv	vices affecting 1 of 3 audited				
	staff (the Resource C	enter Director (RCD)); and				
		al refresher training was				
		nually affecting 1 of 3				
	sampleted at least all		I			1

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 9 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BUILDING:	
		MHL049-116	B. WING		12/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CHESTNU	T GROVE	303 SAIN	T ANDREWS RO	DAD	
		STATESV	ILLE, NC 28625		
(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 537	Continued From page	9	V 537		
	audited staff (#1). The	e findings are:			
	record revealed: - Hire date: 2/24/2020 - Documentation that physical restraint and expired on 3/3/2021 Refresher training w 7/13/2021.  Reviews on 12/16/2021.  RCD's employee recordant date: 2/22/2021 - Documentation that physical restraint and begun until 6/9/2021 No documentation the	training in seclusion, isolation time out had ras not completed until 21 & 12/17/2021 of the ord revealed:			
	- She remembered has seclusion, physical re	21 with Staff #1 revealed: ave attended the training in straint and isolation time why it had taken so long for er training.			
	- She had attended the training in seclusion, isolation time out curre attended the final pare. The Human Resource	iculum but had not yet t. ces Manager (HRM) had onsible for scheduling her s hired.			
	Resources Manager I - Training in seclusion				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 10 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3			SURVEY LETED	
MHL049-116			B. WING		12/	17/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CHESTNU	JT GROVE		ANDREWS ROLLE, NC 28625			
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	the RCD due to COVI to class size and the I - 4 of the 5 trainers in had left, leaving the for one person. - The RCD had starte training in seclusion, I	ID-19 pandemic restrictions ack of available trainers. the local Licensee office all load of training all staff on daking the first part of the	V 537			

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 11 of 11